

**RELEASE OF RECORDS / AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**SECTION A: Must be Completed for all Authorizations**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient.

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **ID NUMBER:** \_\_\_\_\_

**ORGANIZATION PROVIDING THE INFORMATION:**

**PERSONS / ORGANIZATIONS RECEIVING THE INFORMATION:**

**Please complete and submit request by**

**Name :** \_\_\_\_\_

**MAIL OR FAX to:**

**Address:** \_\_\_\_\_

St. Cloud Surgical Center  
1526 Northway Drive  
St Cloud, MN 56303  
Phone 320-229-3231  
Fax: 320-217-2474

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**DATE(S) OF SERVICE:** \_\_\_\_\_

**INFORMATION REQUESTED (Check all pertaining items):**

Anesthesia Report     
  Discharge Summary     
  Entire Billing Record  
 Operative Report     
  Pathology Report     
  Other: \_\_\_\_\_

**Purpose of the Use or Disclosure:** \_\_\_\_\_

**FORMAT REQUESTED (3 options):**

Mail     
  Pick Up at St. Cloud Surgical Center

Email: \_\_\_\_\_

(By choosing this option, I acknowledge there may be security risks to my health information while in transit)

**SECTION B: Must be Completed by the Patient or Patient Representative for all Authorizations**

The patient or the patient's representative must read the following statements then sign where indicated:

**I Understand That:**

- 1) This authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research related treatment which may be conditioned upon this authorization.
- 2) The authorization will expire on    /    /    (fill in date if less than 1 year) or 1 year from date signed.
- 3) I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any action taken before receiving the revocation.
- 4) St Cloud Surgical Center may impose a fee to cover the cost of labor, copying and postage.

*I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations for specific issues including but not limited to the following: HIV/AIDS, mental health, alcohol and substance abuse, minors, fees, industrial accidents, disability, birth defects, cancer, and genetic information.*

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Date**

*(Form MUST be completed before signing)*

**Printed Name of Patient's Representative**

**Relationship to the Patient:** \_\_\_\_\_