

# RELEASE OF INFORMATION - AUTHORIZATION FORM



## Authorization to Release Health Information

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| <b>Patient Information:</b>                                   | Name: _____ Maiden Name/Alias: _____<br>Date of Birth: _____ Social Sec. #: _____<br>Phone: _____ MR# _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                                                      |                                                               |                                                       |                                             |                                            |                                                |                                                |                                         |                                    |                                      |                                        |                                       |                                            |  |                                                                    |  |                                               |  |                                        |  |                                              |
| <b>Health Information Released FROM:</b>                      | <input type="checkbox"/> Hennepin County Medical Center (Hospital and Clinics)<br><input type="checkbox"/> Hennepin County Adult Detention Center<br><input type="checkbox"/> Other:<br>Person/Organization: _____<br>Street Address: _____<br>City/State/Zip: _____<br>FAX: _____ Phone: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |                                                      |                                                               |                                                       |                                             |                                            |                                                |                                                |                                         |                                    |                                      |                                        |                                       |                                            |  |                                                                    |  |                                               |  |                                        |  |                                              |
| <b>Health Information Released TO:</b>                        | Person/Organization: _____<br>Street Address: _____<br>City/State/Zip: _____<br>FAX: _____ Phone: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                              |                                                      |                                                               |                                                       |                                             |                                            |                                                |                                                |                                         |                                    |                                      |                                        |                                       |                                            |  |                                                                    |  |                                               |  |                                        |  |                                              |
| <b>Health Information to be Released:</b>                     | <table border="0"> <tr> <td>Date of Service: _____</td> <td>Type of Visit: _____</td> </tr> <tr> <td><input type="checkbox"/> History and Physical</td> <td><input type="checkbox"/> Photographs</td> </tr> <tr> <td><input type="checkbox"/> Laboratory Reports</td> <td><input type="checkbox"/> Discharge Summary</td> </tr> <tr> <td><input type="checkbox"/> Emergency Room Report</td> <td><input type="checkbox"/> Progress/Clinic Notes</td> </tr> <tr> <td><input type="checkbox"/> Surgery Report</td> <td><input type="checkbox"/> Care Plan</td> </tr> <tr> <td><input type="checkbox"/> Medications</td> <td><input type="checkbox"/> Immunizations</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Radiology Reports</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Radiology Images (not able to fax images)</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Dental Report/X-rays</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Visits Report</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Cardiac/EKG Reports</td> </tr> </table> <p><b>All information regarding alcohol/ drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:</b></p> <p>_____ Do Not Release Alcohol/Drug Use or Abuse records</p> <p>_____ Do Not Release Mental Health records</p> <p>_____ Do Not Release HIV/AIDS records</p> | Date of Service: _____                       | Type of Visit: _____                                 | <input type="checkbox"/> History and Physical                 | <input type="checkbox"/> Photographs                  | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Progress/Clinic Notes | <input type="checkbox"/> Surgery Report | <input type="checkbox"/> Care Plan | <input type="checkbox"/> Medications | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Radiology Reports |  | <input type="checkbox"/> Radiology Images (not able to fax images) |  | <input type="checkbox"/> Dental Report/X-rays |  | <input type="checkbox"/> Visits Report |  | <input type="checkbox"/> Cardiac/EKG Reports |
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| <b>Authorization/ Revocation</b>                              | <p>This authorization will terminate in one year unless otherwise specified.</p> <p>I understand that I may stop this release at any time by writing to the HCMC's HIM department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that HCMC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information.</p> <p>X _____ X _____<br/>         Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date</p> <p>Relationship to patient (if not patient)<br/> <b>NOTE:</b> An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.<br/> <i>A photocopy of this authorization is as valid as the original.</i></p>                                                                                                                                                                        |                                              |                                                      |                                                               |                                                       |                                             |                                            |                                                |                                                |                                         |                                    |                                      |                                        |                                       |                                            |  |                                                                    |  |                                               |  |                                        |  |                                              |
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# Fake Hospital Discharge Papers Rex Hospital Nc

**Rosina Ehmann**



**Fake Hospital Discharge Papers Rex Hospital Nc:**

## **Fake Hospital Discharge Papers Rex Hospital Nc** Book Review: Unveiling the Power of Words

In a world driven by information and connectivity, the ability of words has are more evident than ever. They have the capability to inspire, provoke, and ignite change. Such is the essence of the book **Fake Hospital Discharge Papers Rex Hospital Nc**, a literary masterpiece that delves deep in to the significance of words and their effect on our lives. Published by a renowned author, this captivating work takes readers on a transformative journey, unraveling the secrets and potential behind every word. In this review, we will explore the book is key themes, examine its writing style, and analyze its overall effect on readers.

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