

# RELEASE OF INFORMATION – AUTHORIZATION FORM



## Authorization to Release Health Information

<b>Patient Information:</b>	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ Social Sec. #: _____ Phone: _____ MR#: _____	
<b>Health Information Released FROM:</b>	<input type="checkbox"/> Hennepin County Medical Center (Hospital and Clinics) <input type="checkbox"/> Hennepin County Adult Detention Center <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____	
<b>Health Information Released TO:</b>	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____	
<b>Health Information to be Released:</b>	Date of Service: _____ Type of Visit: _____ <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> History and Physical  <input type="checkbox"/> Laboratory Reports  <input type="checkbox"/> Emergency Room Report  <input type="checkbox"/> Surgery Report  <input type="checkbox"/> Medications  <input type="checkbox"/> Other: _____         </div> <div> <input type="checkbox"/> Photographs  <input type="checkbox"/> Discharge Summary  <input type="checkbox"/> Progress/Clinic Notes  <input type="checkbox"/> Care Plan  <input type="checkbox"/> Immunizations         </div> <div> <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         </div> </div> <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>	
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## **Table of Contents Fake Hospital Discharge Papers Des Moines Ia**

1. Understanding the eBook Fake Hospital Discharge Papers Des Moines Ia
  - The Rise of Digital Reading Fake Hospital Discharge Papers Des Moines Ia
  - Advantages of eBooks Over Traditional Books
2. Identifying Fake Hospital Discharge Papers Des Moines Ia
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Fake Hospital Discharge Papers Des Moines Ia
  - User-Friendly Interface
4. Exploring eBook Recommendations from Fake Hospital Discharge Papers Des Moines Ia
  - Personalized Recommendations
  - Fake Hospital Discharge Papers Des Moines Ia User Reviews and Ratings

- Fake Hospital Discharge Papers Des Moines Ia and Bestseller Lists
- 5. Accessing Fake Hospital Discharge Papers Des Moines Ia Free and Paid eBooks
  - Fake Hospital Discharge Papers Des Moines Ia Public Domain eBooks
  - Fake Hospital Discharge Papers Des Moines Ia eBook Subscription Services
  - Fake Hospital Discharge Papers Des Moines Ia Budget-Friendly Options
- 6. Navigating Fake Hospital Discharge Papers Des Moines Ia eBook Formats
  - ePub, PDF, MOBI, and More
  - Fake Hospital Discharge Papers Des Moines Ia Compatibility with Devices
  - Fake Hospital Discharge Papers Des Moines Ia Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Fake Hospital Discharge Papers Des Moines Ia
  - Highlighting and Note-Taking Fake Hospital Discharge Papers Des Moines Ia
  - Interactive Elements Fake Hospital Discharge Papers Des Moines Ia
- 8. Staying Engaged with Fake Hospital Discharge Papers Des Moines Ia
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Fake Hospital Discharge Papers Des Moines Ia
- 9. Balancing eBooks and Physical Books Fake Hospital Discharge Papers Des Moines Ia
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Fake Hospital Discharge Papers Des Moines Ia
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Fake Hospital Discharge Papers Des Moines Ia
  - Setting Reading Goals Fake Hospital Discharge Papers Des Moines Ia
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Fake Hospital Discharge Papers Des Moines Ia
  - Fact-Checking eBook Content of Fake Hospital Discharge Papers Des Moines Ia
  - Distinguishing Credible Sources

13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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