

RELEASE OF INFORMATION – AUTHORIZATION FORM



Authorization to Release Health Information

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ Social Sec. #: _____ Phone: _____ MR# _____	
Health Information Released FROM:	☐ Hennepin County Medical Center (Hospital and Clinics) ☐ Hennepin County Adult Detention Center ☐ Other: Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____	
Health Information Released TO:	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____	
Health Information to be Released:	Date of Service: _____ Type of Visit: _____ ☐ History and Physical ☐ Laboratory Reports ☐ Emergency Room Report ☐ Surgery Report ☐ Medications ☐ Other: _____ ☐ Photographs ☐ Discharge Summary ☐ Progress/Clinic Notes ☐ Care Plan ☐ Immunizations ☐ Radiology Reports ☐ Radiology Images (not able to fax images) ☐ Dental Report/X-rays ☐ Visits Report ☐ Cardiac/EKG Reports 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: _____ Do Not Release Alcohol/Drug Use or Abuse records _____ Do Not Release Mental Health records _____ Do Not Release HIV/AIDS records	
Type of Release:	☐ Hard Copies (paper) ☐ CD (requires PDF viewing capability) ☐ Verbal Exchange (no copies) ☐ Review of Record (no copies)	
Purpose of Release:	☐ Personal ☐ Attorney ☐ Continued Care - Appt Date: _____ ☐ Insurance ☐ Disability/ Social Security ☐ Other: _____ There may be a charge/fee for copies of records.	
Delivery Method	☐ Mail ☐ Fax ☐ Pick up by patient/authorized designee (requires photo ID)	
Authorization/ Revocation	This authorization will terminate in one year unless otherwise specified. 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. X _____ X _____ Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date Relationship to patient (if not patient) NOTE: 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. <i>A photocopy of this authorization is as valid as the original.</i>	
Staff Use Only	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____	

Fake Miscarriage Hospital Discharge Papers

Victor M. Corman



Fake Miscarriage Hospital Discharge Papers:

Fake Miscarriage Hospital Discharge Papers Book Review: Unveiling the Power of Words

In a global driven by information and connectivity, the energy of words has be more evident than ever. They have the capacity to inspire, provoke, and ignite change. Such could be the essence of the book **Fake Miscarriage Hospital Discharge Papers**, a literary masterpiece that delves deep into the significance of words and their effect on our lives. Written 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 affect readers.

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address complete a b or c below a to the best of my knowledge and belief i am the nearest relative within the meaning of the
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