



**MeritCare**

**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

Name of Patient \_\_\_\_\_ Chart No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(optional)

I authorize: \_\_\_\_\_ To release to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED  
(specify dates for each, unless "entire medical record" is selected)**

\_\_\_\_\_ MeritCare treatment from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)  
\_\_\_\_\_ Hospital Admission Summary \_\_\_\_\_ Lab Reports  
\_\_\_\_\_ Hospital Discharge Summary \_\_\_\_\_ X-ray Reports  
\_\_\_\_\_ Operative Report \_\_\_\_\_ X-ray Films/CD  
\_\_\_\_\_ Progress Notes/Clinic Notes \_\_\_\_\_ Psychiatric Intake  
\_\_\_\_\_ Entire Medical Record for all dates \_\_\_\_\_ Immunizations  
\_\_\_\_\_ Billing Information \_\_\_\_\_ Pathology Report  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Verbal discussion only – do not release any written records

**I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART  
OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:  
Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.**

**PURPOSE OF THE USE AND DISCLOSURE**

\_\_\_\_\_ Further Treatment (Date of Appointment \_\_\_\_\_)  
\_\_\_\_\_ Insurance Application \_\_\_\_\_ Personal Records  
\_\_\_\_\_ Disability Determination \_\_\_\_\_ Education  
\_\_\_\_\_ Vocational Rehabilitation Evaluation \_\_\_\_\_ Payment of Insurance Claims  
\_\_\_\_\_ At my request \_\_\_\_\_ Legal  
\_\_\_\_\_ Other \_\_\_\_\_

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: \_\_\_\_\_ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

Signature of Patient/Guardian/Representative \_\_\_\_\_ Date \_\_\_\_\_

(If not patient, state authority/relationship)  
Authorization for Use and Disclosure of Information