

LAKEVIEW HOSPITAL
Health Information Services
Stillwater, Minnesota
Phone 651-430-4596 Fax 651-430-4660
**Authorization for the Release of and/or Request for
Patient Access to Health Information**

I, _____ (patient name), Request to review, and/or request copies of, and/or Authorize Lakeview Hospital to disclose to:

(name and address)

the following information from the medical record maintained while I was/am a patient at Lakeview Hospital during _____ (List all dates of treatment/Hospitalizations requested)

The information to be disclosed is:	_____ X-ray reports	_____ Copies of x-ray film
_____ Complete record	_____ History and physical	_____ Complete ED record
_____ Discharge summary	_____ Operative reports	
_____ Consultation reports	_____ All lab reports	
_____ Pathology reports	_____ Specific lab reports: _____	
_____ ECG reports	_____ Emergency dept. reports	
_____ EEG reports	_____ Itemization of charges	
_____ Other (Specify) _____		

The information is needed for the following purpose (s): _____

The release of requested reports may include information regarding mental health, drug, alcohol and HIV results unless specified NOT to release this information _____

I understand that I may revoke this authorization in writing at any time and that upon fulfillment of the above state purpose (s), this authorization will automatically expire without my express revocation.

(Date) (Signature of patient or patient representative) (relationship to patient)

(Reason patient unable to sign) (Signature of witness)

For Hospital Staff Use Only:

Requests made upon discharge from hospital (HUC or Nurse to complete)

- Completed and sent with patient
- Request sent to HIS for completion and
 - Patient to pick up _____ (Date)
 - Send to above requested address

HIS Staff: ID Checked when records were picked up on _____ (Date)
 Records were sent or faxed on _____ (Date)

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under the privacy rule.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT THE CONSENT OF THE PATIENT/CLIENT.

----- (COMPLETE IN INK) -----