ST. CLOUD EAR, NOSE & THROAT
1528 Northway Drive, St. Cloud, MN 56303
*Tel 320-252-0233 * 800-450-3223 * Fax 320-252-1421*

Patient Authorization Form For Release of Medical Information

______________________________ _______________________ ____________________
(Print Patient Name) Social Security # (Last 4 Digits) (Date of Birth)

The information to be released is (include dates if applicable):

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For Release of Medical Record Information: I hereby authorize and request the St. Cloud Ear, Nose & Throat (the "Clinic") to copy and release information prepared & maintained by the Clinic in its medical record dedicated to the Patient identified above to the following entity or individual except as may limited in the Restrictions and Limitations section of this authorization:

____
Name of Provider or Entity or Person

____
Enter Street Address if Applicable

____
Enter City, State, Zip Code if Applicable

Restrictions and Limitations: I understand that medical record information may contain sensitive health information such as that related to the treatment of drug or alcohol abuse, mental health conditions, or HIV/AIDS, STD, etc. I further understand that I may limit the type and amount of information to be released or collected by a signed and dated writing that provides specific restrictions to the Privacy Officer for the Clinic or as I now limit by the following description:
(Describe any treatment, payment, time, place, provider, entity, person or operational limitations, etc.)

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Time Period: This authorization relates to records prepared or collected by the Clinic prior to the date of signature on this authorization and also includes records prepared or collected by the Clinic after the date of the signature on this authorization for a period of one year.

Signature: This authorization will remain in effect for a period of one year from the date of signature. However, I may revoke this authorization at any time, through a writing that is signed, dated, and effectively presented to the Clinic for processing. I understand that such revocation does not apply to any information already released or collected, in good faith, by the Clinic. I also understand that a facsimile or photocopy of this authorization shall be valid as the original signed and dated document.

Furthermore, I understand that if the entity or person that I authorize to receive medical record information is not a provider or health plan, the released information could be re-disclosed and such disclosure may not be protected by federal privacy regulations. I understand that the Clinic will not condition its treatment of the person identified above by Patient Name on whether or not this form is signed unless otherwise permitted by law or described in the Notice of Privacy Practices for the Clinic.

____ ________________________
Signature of Patient or Authorized Representative Date of Signature

____ ________________________
Relationship to Patient (If applicable) Description of Authority

ALL PATIENTS 18 OR OLDER MUST SIGN BEFORE RECORDS WILL BE RELEASED
RELEASE OF RECORDS MAY BE SUBJECT TO A CHARGE PURSUANT TO MINNESOTA LAW

Form Effective April 14th, 2003