GARDEN COURT CHATEAU

2495 SW 8th Street, Grand Rapids, MN 55744

Phone: (218) 999-5999 Office: (218) 999-5998 Fax:(218) 999-5996

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____

Patient Name

_____

Address

_____

Phone Numbers Home Other

This will authorize: Garden Court Chateau, LLC
2501 Co Rd 76
Grand Rapids, MN 55744

To Release Records To:_____ To Request Records From:_____

NAME/ORGANIZATION_____
STREET ADDRESS_____
CITY_____ **STATE**_____

The following information is to be released:

_____Discharge Summary	_____Emergency Services Reports	_____Films
_____Hospital Outpatient/Clinic Notes	_____Pathology Reports	_____PT/OT Reports
_____History and Physical Exams	_____X-Ray/Radiology Reports	_____Other
_____Consultation Reports	_____Lab Reports	_____

For the following date(s) of treatment or condition:_____
Specific Dates of Treatment or Condition

I am requesting the information be released for the following purpose:

_____Continued Care by another Provider	_____Insurance Claim Purposes	_____Personal Use
_____Attorney Review	_____Other_____	

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness; testing will be released unless otherwise indicated by initialing here:_____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand the revocation will not apply to information that has already been released in response to this authorization
- This authorization will automatically expire one year from the date of my signature, or _____(date specified here). The expiration period noted here may exceed one year only in certain situations as specified in Minnesota Statute 144.335 3a for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigations or quality of care; for release to an external researcher solely for purposes of medical or scientific research.
- I understand there may be a retrieval and copy charge associated with the release of information
- I understand that once information is released pursuant to this authorization, Garden Court Chateau, LLC cannot prevent the re-disclosure of the information to another third party
- I understand this authorization must be filled out completely, signed and dated in order to be considered valid as an original

_____ _____ _____
Signature of patient/resident or authorized person Authorized authority to sign (guardian, power of attorney, etc) Date

Reason Patient/Resident Unable to Sign: _____ Deceased _____ Other _____

Date Faxed/Mailed/Picked Up_____ Initials_____
Comments_____
_____
_____