

Authorization for Release of Health Information



Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I.: _____ Date of Birth: ____/____/____

Community and Room #: _____

Release Information From (Required):

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

Bluestone Physician Services
Attn: Medical Records Dept.
270 Main Street N., Suite 300
Stillwater, MN 55082

FAX: 855-490-4045 PHONE: 877-599-1039

Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

- | | |
|---|---|
| <input type="checkbox"/> Notes from four most recent provider visits | <input type="checkbox"/> Labs and imaging within last two years |
| <input type="checkbox"/> Hospital discharges within last two years | <input type="checkbox"/> Other: _____ |

By law, you must specifically request the following information for it to be released:

- Chemical dependency program: Yes No Behavioral health notes: Yes No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent does not expire unless I write in a specific expiration date here: _____.

I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

Patient or Legal Representative Signature

Date

Legal Representative Printed Name and Authority to sign for patient (i.e. Health Care Directive, Medical POA; must include documentation)