

Big Lake Clinic

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION

Last Name First Name MI _____
Previous Name

_____/_____/_____
Date of Birth _____ - _____
Social Security Number _____
MRN

I authorize Big Lake Clinic to verbally disclose medical information to the individuals listed below.

I agree to the verbal release of information from past, current, or future visits in order to allow the individuals listed below to participate in my care.

I agree that a photocopy of this authorization will be treated in the same manner as the original.

Information related to mental health, chemical dependency, or HIV testing and/or therapy will only be released to the patient.

Name of Individual	Relation to Patient	Information to be disclosed

This authorization will remain in effect a maximum of one year from the date of signature and may be cancelled by me in writing at any time. To cancel or revoke this authorization, I will forward a written notice to Medical Information – Big Lake Clinic, PO Box 539, Big Lake, MN 55309.

This information once released will no longer be protected under the Federal Privacy Laws.

Signature of Patient/Guardian _____/_____/_____
Date _____
Relationship to Patient

Witness if Patient is unable to sign _____/_____/_____
Date _____
Reason Patient is unable to sign

All items on this form must be completed to ensure accurate disclosure of information. If the form is incomplete, it will be returned and no medical information will be disclosed until it is properly completed.