GLACIAL RIDGE
HEALTH SYSTEM
heartfelt care®

How to Transfer Your Medical Records

If you would like to transfer your medical records to Glacial Ridge Health System – hospital and clinics – please download and complete the Authorization to Disclose Health Information form below. Please print clearly and fill out as much information as possible. If you are unsure of specific dates, please give a range of dates or specific information you are looking for to help us find the correct medical information. Sign and date the form at the bottom.

You may return the completed form by fax to 320.634.2244 or by mail:

Glacial Ridge Health System
Attn: Clinic HIM
10 4th Ave. SE
Glenwood, MN 56334

Please allow 7 – 10 days for processing. We will call you when your records are received.

If you have any questions, please call 320.634.4521 and ask for Clinic HIM.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Organization Releasing Information:

_____ Patient Name: _____

_____ DOB: _____ Phone Number:_____

_____ Medical Record #: _____

The undersigned hereby authorizes the above-identified hospital or clinic to release health information to :

_____**Glacial Ridge Health System – Clinic HIM** _____

_____**10 4th Ave SE, Glenwood, MN 56334** _____

The information is to be released for the following purpose:

☐ Continuing Care ☐ Litigation ☐ Insurance Claim (s) ☐ Other (Explain) _____

This authorization to disclose health information is limited to the following:

☐ 1. Indicate the time periods (dates) for which these records are being released:

From _____ to _____

☐ 2. Specific information from my medical record:

☐ History and Physical ☐ X-ray Report(s)

☐ Discharge Summary ☐ Laboratory Report(s)

☐ Operative Report(s) ☐ Other_____

☐ Pathology Report(s) ☐ Clinic Visit(s)

☐ Consultation Report(s) ☐ Entire record

I understand that the information in my health record may include information relative to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date I signed it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer.

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT IF SIGNED BY LEGAL REPRESENTATIVE

_____ _____

DATE OF PATIENT'S SIGNATURE WITNESS