Astera Health
415 Jefferson St. N., Wadena, MN 56482
218-631-3510 or Toll-Free **800-631-1811**
ROI Fax# 218-631-7571

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize: *(Who has your records?)*

_____
_____
_____
_____

To release to: *(Who needs your records?)*

_____
_____
_____
_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED:

Treatment from _____ / _____ / _____ to _____ / _____ / _____ *(If blank, we will release one year's worth of most recent records)*

- ❑ Progress/Clinic Notes
- ❑ Radiology Report
- ❑ Radiology Film
- ❑ Lab Reports
- ❑ Pathology Report
- ❑ Operative Report
- ❑ ER Reports
- ❑ Immunizations
- ❑ Medications
- ❑ Hospital Admission/Discharge Summary
- ❑ Photographs
- ❑ Billing
- ❑ Consults
- ❑ PT/OT/ST Notes
- ❑ Other (please specify): _____

I AUTHORIZE RELEASE OF ALL ALCOHOL, DRUG ABUSE, MENTAL HEALTH AND HIV/AIDS RECORDS THAT ARE PART OF ABOVE, UNLESS OTHERWISE INDICATED HERE:

❑ Do not release records from alcohol or drug abuse treatment programs, mental health and HIV/AIDS records that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE:

- ❑ Legal
- ❑ Personal Records
  - ❑ Release to MyChart ❑ Paper Copies
- ❑ Further Treatment (Date of appointment _____ / _____ / _____)
- ❑ Other (please specify): _____
- ❑ Insurance Application and Claims
- ❑ Disability Determination

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not patient, state authority/relationship)

❑ *When this box is checked, we will charge a fee for copying your records. The fee will be $_____.*

Astera Health shares an electronic medical record with CentraCare Health (CCH). CentraCare Health shares an electronic medical record with non-CCH organizations. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record. A list of these non-CCH organizations will be provided to the patient upon request.

Authorized by: _____ Completed: _____ Initials: _____
A photocopy or fax of this authorization will be treated in the same manner as the original.