Directions for Completion of
Authorization for Release of Health Information

Patient Information: Complete the entire section which identifies clearly the demographic information specific to the patient (individual who information is being requested for).

Release Information From: Identify which CentraCare hospital, clinic, or provider you are seeking information from. Please be specific in your request. Please see www.centracare.com for a listing of all CentraCare hospital and clinic locations.

Release Information To: Identify the full name of individual, business, hospital, clinic, or provider you want to receive your records. Be sure to include their address and phone number.

Information to Be Released: This section gives us the instructions for what information you want released. It is very helpful to identify the date or range of dates needed. If you do not have dates noted, only your last hospital encounter or clinic visit at the specific CentraCare location you indicated will be released. Only the specific information checked will be released.

Special Disclosure: This section is required per Federal Rule 42 CFR Part 2 to be completed in full to allow CentraCare to release Substance Use Disorder records. Even if you have indicated dates in the Information to be Released section, the dates of Substance Use Disorder records to be released is required in this section.

Preferred Method: This tells us how you would like your information provided. We can print the records, burn them to a CD, or release them to your MyChart portal. Note: If your original records are on paper, we are only able to provide them on paper.

Reason for Release: Please identify the reason you need a copy of your record. This helps us track and assign a priority status to your request. It also informs us determine who may be responsible for the cost of records (where applicable).

Revocation: This authorization will automatically expire 1 year after your signature unless you indicate another date or event upon which the authorization should expire OR you provide a written revocation to our organization.

Please send your completed authorization to: Attn: Health Information Management Department at the appropriate site listed on Page 2 of the authorization.