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AUTHORIZATION OF RELEASE OF INFORMATION

Patient's Name: _____

Date of Birth: _____

I request and authorize **TimeWise Medical** to receive / disclose healthcare information to/from:

Clinic/Organization/Individual: _____

Address: _____

Phone: _____ Fax: _____

This request and authorization request applies to:

- | | |
|---|---------------------------|
| <input type="checkbox"/> General Medicine | Date(s) of Service: _____ |
| <input type="checkbox"/> Pain Management | Date(s) of Service: _____ |
| <input type="checkbox"/> M.A.T Program | Date(s) of Service: _____ |

ONLY record type checked below:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Treatment Plan & Review | <input type="checkbox"/> Progress/Clinic Notes | <input type="checkbox"/> MN Prescription Monitoring Program | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Drug Screens | <input type="checkbox"/> MRI | <input type="checkbox"/> Bone Density |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Other: _____ | |

The above information is needed for the specific purpose(s):

- | | | |
|---|---|--|
| <input type="checkbox"/> Continuing care | <input type="checkbox"/> Verify prescribed medication | <input type="checkbox"/> Insurance payment/claim |
| <input type="checkbox"/> Transfer of care | <input type="checkbox"/> Personal use or review | <input type="checkbox"/> Other: _____ |

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidential of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise proved for in the regulations. I understand that TimeWise Medical will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. Once the health information has been released to another facility/provider/individual, there is no way to cancel or stop the release. I understand that when the health information is released, the information could be re-disclosed by the third party that received it and may no longer be protected by federal or state privacy laws. I understand that I may revoke this consent at any time, verbally or in writing, except to the extent that action has been taken in reliance on it and that any event that consent expires one year of my signature unless specified. Expiration Date: _____

Signature: _____

Date: _____

This information has been disclosed to you from records protected by Federal Confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of information to criminally investigate or prosecute any alcohol or drug abuse patient. If you have received this message/fax in error, please shred all documents. Any duplication of items is prohibited. Contact TimeWise Medical at 651-333-9133 immediately.