integrity
MEDICAL CENTER

Steven E. Parnell, M.D.

Authorize for Release of Medical Information

First Name _____ Middle Initial _____ Last Name _____
Mailing Address _____
City_____ State _____ Zip Code _____
Home Phone Number _____ Cell Phone_____
Patient's Date of Birth _____ Email_____
Information to be: Mailed _____ Faxed_____ Picked up_____
Release information From:_____
Release information To: Integrity Medical Center_____
Address: 717 S State St. Suite 600, Fairmont MN 56031_____
Phone Number: 507-235-2924_____ Fax Number: 507-235-2923_____

Information to be disclosed:

___Notes from last visit
___Provider Progress Notes from last 2 years
___Preventative Health Flow Sheet
___Immunization Records
___Current Medication List
___Lab Reports from last 2 years
___EKG Reports
___Psychiatry Notes from last 2 years
___Hospital History and Physical Exams
___Hospital Discharge Summaries
___Operative Notes
___Pathology Reports
___Consultations
___Radiology/Mammogram Report

Reason for Disclosure: Further Care

Authorization:
I understand that Integrity Medical Center cannot condition treatment based on my signing this authorization. I understand that I may revoke this consent at any time, but that such a revocation will only be effective upon written notice to Integrity Medical Center. I do not authorize re-disclosure of this information to anyone but understand that in the event there is an unauthorized disclosure by the recipient of this information, the protected health information is no longer protected by Federal Privacy Guidelines. This authorization will automatically expire one year from the date of my signature.

Signature:_____ **Date:**_____

***Any patient 18 or older must sign for themselves. If signed by a person other than the patient, state relationship below.**

Patient is: ___Minor ___Incompetent ___Disabled
Legal Authority: ___Legal Guardian ___Healthcare POA ___Parent of Minor

healing from the inside out