How to fill out an Authorization to Disclose Protected Health Information:

We need the "WHO, WHAT, WHERE, WHY, AND WHEN" with an authorized signature and dated

1. Fill in the patient's **name** and **date of birth** and, if you know it the medical record **number**.
2. Mark whether you are giving permission to SCHRC to **send and/or receive** your information.
3. Fill in the **person(s) and/or agency** SCHRC is releasing to or receiving from with **address, fax number, email, and/or phone number** – as much information as is needed to accomplish your request.
4. Indicate **what information** you want sent or received.
5. Indicate a **purpose** in the next section.
6. All releases **expire in one year** in Minnesota. If you want it to expire before then, fill in that **sooner date**.
7. Indicate whether this release applies to **future information or not**.
8. **Patients sign** on the first signature line and **date**.
9. If someone **other than the patient** is signing for the patient, explain **who you are** and **why you can sign** for them, then **sign** and **date**. If you are someone **other than a parent**, we will need **court** documents or **Medical Power of Attorney** forms included.

YOU MAY REVOKE YOUR CONSENT AT ANY TIME BY SIGNING AND DATING THE BOTTOM LINE