CONSENT TO THE RELEASE OF HEALTH CARE INFORMATION NORTH STAR LODGE

For your privacy protection, we will not disclose your information to others unless you give us permission to do so or unless the law authorizes or requires us to do so. We recognize that you may want us to provide information to friends or family members and to do so we need your written permission. Please complete each section below.

1

☐ **Do not release health care information to anyone – skip to Section #3**
OR
☐ **You may disclose my health care information to:**

Please provide up to two names. Calls from other persons will be referred to you or your contact person(s) to provide them with information about your treatment.

1. NAME _____ PHONE NUMBER _____

2. NAME _____ PHONE NUMBER _____

2

North Star Lodge may use or disclose the following health care information to the individuals above (check all that you would like to apply below)

☐ All health care information in my medical record at North Star Lodge
☐ Health care information in my medical record relating to the following treatment or condition(s):
_____
☐ Health care information in my medical record for the date(s):_____
☐ Other _____

3

_____ _____
Patient signature (or legal guardian) Date Time

_____ _____
Printed name of patient Date of Birth

_____ _____
Printed name if signed on behalf of patient Relationship

****This consent will remain in effect until the conclusion of care at North Star Lodge****

You may revoke or change this consent at any time by notifying the North Star Lodge Medical Records Department in writing. Revocation of this consent cannot be retroactive to a release of information made in good faith. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person may re-disclose it, at which time it may no longer be protected under Privacy Laws. North Star Lodge will not withold treatment if you do not sign this consent.

Please see reverse side: you may choose different contacts for disclosure of *financial* information, OR

☐ **You may use the same contacts as above for disclosure of health care related financial information.** _____ **Initials**