RELEASE OF INFORMATION – AUTHORIZATION FORM

Hennepin Healthcare

Authorization to Release Health Information

Patient Information	Name			MRN:
	Maiden Name/Alias			
	Phone #:	Date of Birth:		SSN:
Release Information FROM:	□ Hennepin Healthcare System (Hospital & Clinics) □ Other Healthcare Provider/Organization:_________________________		□ MVNA Home Care & Hospice □ Hennepin County Adult Detention Center	
	Street Address			Phone #
	City	State	Zip Code	Fax #
Release Information TO:	□ Hennepin Healthcare System (Hospital & Clinics) □ Other Organization/Person:_____________________________________			
	Street Address			Phone #
	City	State	Zip Code	Fax #

Information to be Released:

□ **Health records from these dates of service:**_______________________________
- □ All Clinic Visit(s) □ All Hospital Care

□ **Health records related to this diagnosis/condition:**_________________________
- □ All related records

□ **Individual Reports/Results**

□ History and Physical	□ Emergency Room Report(s)	□ Laboratory/Pathology Report(s)	□ Radiology Report(s)
□ Discharge Summary	□ Progress/Clinic Notes	□ Immunizations	□ Radiology Images
□ Surgery/Operative Report(s)	□ Care Plan	□ Medications	□ Dental Report/X-Rays
□ Consult Report(s)	□ Visits Report	□ Photographs	□ Cardiology/EKG Report(s)

□ **Other** (Please specify):_____________________

Special Permissions:

All information regarding alcohol/drug use or abuse, mental health care, and/or HIV/AIDS WILL BE RELEASED unless you tell us NOT to by initialing below:

_____ Do **NOT** release Alcohol/Drug Use or Abuse records _____Do **NOT** release HIV/AIDS records
_____ Do **NOT** release Mental Health records

Purpose of Release:

□ Personal / My Request □ Transfer of Care □ Continuity of Care *(specify date of appointment or date needed)*:
□ Legal / Attorney □ Disability / Social Security
□ Insurance

Form of Release:

□ Copies of Records *(paper or electronic)* □ Verbal Exchange *(no copies)* □ Review of Records *(no copies)*

Delivery Method:

□ **Pick up** (photo ID required) **by patient/authorized designee** *(choose format):* □ Paper □ CD
□ **Mail** *(choose format):* □ Paper □ CD
□ **Fax** *(Please note: Radiology images cannot be faxed)*
□ **Release to MyChart** (patient portal)
□ **Secure Email** (specify email address):

Authorization & Revocation

This authorization will terminate in one year unless otherwise specified: ____

- I understand that I may stop this release at any time by writing to the HHS's HIM department. Once the health information has been released to another facility or provider, 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 receives it and may no longer be protected by federal or state privacy laws.
- I understand that there may be a charge for records.
- I understand that HHS 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.

X ____ X __________________________

Signature (If signing for a minor, I hereby state that my parental rights have not been revoked by a court of law.) **Date**

NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.

____
Relationship to patient (if not patient)

A photocopy of this authorization is as valid as the original.

STAFF USE ONLY
Info Released By:___________________ Date: ____________ Form of ID: DL / State ID / Passport / Other: ________________

Instructions for Completing the Authorization to Release Health Information

To protect our patient's confidential medical information, we must have a valid, complete and legible authorization to disclose their health information.

1. **Patient Information**: Clearly print all requested patient demographics.

2. **Release Information FROM:** Check only **one** of the boxes. If you select Hennepin Healthcare System it will include clinics, emergency room and hospital records; unless otherwise noted. If choosing "Other" please provide the organization's name and address from which to obtain information.

3. **Release Information TO:** Print the name of the person or organization that is to receive the information. Be sure to include the complete address, city and state and/or fax number.

4. **Information to be Released:** Indicate a date of service, type of visit (clinic, inpatient, radiology, etc.) or specific report types as listed on the form.

5. **Special Permissions:** All sensitive information, including alcohol and drug use/abuse records, mental health records and HIV/AIDS records will be released UNLESS the individual items are initialed. Initial each line indicating the specific sensitive information you DO NOT want us to release.

6. **Purpose of Release:** Check appropriate box or write in if other purpose. If you have an upcoming appointment that these records are needed for, please provide the appointment date.

7. **Form of release**:
   a. **Copies of records –** check this box if you are allowing paper or electronic copies of your information to be given to the recipient listen for #3 above. Be sure to indicate what information should be release in the *Information to be Released* section. If choosing to have them sent electronically, your information will sent as a PDF file to the party listed in #3 via an electronic form such as a CD, USB flash drive or email.
      Please note: *Emailing patient information in an unencrypted email is a risk to your private health information. Email accounts can be compromised or emails in transit can be intercepted. By choosing a release via email, you recognize and accept this risk.*
   b. **Verbal Exchange –** Check this box if you are allowing verbal discussions of your health and billing information with parties listed**.**
   c. **Review of Records –** check this box if you are allowing the review of your medical record by the party listed in #3 above.

8. **Delivery Method:** Please check the box to indicate how the records should be sent to the party in #3.
   a. **Pick up by patient/designee –** check this box if you want to have the information picked up. Whomever you would like to pick up the information will need to be listed as the party in #3. The person picking up the information will need to have a valid photo identification card.
   b. **Mail –** if you check this box, please make sure you have a complete address for the party in #3.
   c. **Fax –** check this box for **continued care release only** and be sure to include a fax number for the party in #3.
   d. **Release to MyChart** – you must have an active MyChart account to use this option.
   e. **Email** – be sure to include the email address and confirm its accuracy.

9. **Authorization/Revocation:** The patient or legal representative must sign and date the authorization in order for it to be valid. If a legal representative signs we will need a copy of a document showing legal representation.

If help is needed to complete this form, you may contact the HHS HIM Release of Information staff at 612-873-3180 or ReleaseOfInformation@hcmed.org.
Staff is available to answer calls and emails during the times listed below:

Monday - Friday, 8:00 AM – 4:30 PM
Closed Saturdays, Sundays and Major Holidays