# Patient Authorization for Release of Protected Health Information

AUTHR

1. Review and complete all sections of the form.
2. Click the PRINT button at the bottom of the page, then sign, date and submit to your clinic.
3. To print the blank form, do not fill out the boxes and click the PRINT button at the bottom of the page.
4. Call 952-993-7600 with questions.

Help

**Instructions for completing and mailing this form are on page 2.**

## Patient Information

| Patient name | Previous last name (if any) | Phone number |
|---|---|---|
| | | |

| Street address | City | State | ZIP code | Date of birth |
|---|---|---|---|---|
| | | | | |

## Release my records from:

- ☐ Amery Hospital & Clinics
- ☐ HealthPartners Central MN Clinic
- ☐ HealthPartners Medical Clinics: location _____
- ☐ Hudson Hospital & Clinics
- ☐ Hutchinson Health Hospital & Clinics
- ☐ Lakeview Hospital
- ☐ Methodist Hospital
- ☐ Olivia Hospital & Clinic
- ☐ Park Nicollet Clinics/TRIA: location _____
- ☐ Regions Hospital & Clinics
- ☐ Stillwater Medical Group
- ☐ Westfields Hospital & Clinics

☐ External/Outside facility ***(complete this section only if requesting outside records)***

| Phone number | Fax number |
|---|---|
| | |

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

## Send my records to:

| Person/Business/Hospital/Clinic | Phone number | Fax number |
|---|---|---|
| | | |

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

## Information to be released

- *check only what applies*
- *there may be a charge for records*
- *instructions on back of form*

**I want health records related to this diagnosis/condition** ▸ _____

**I want health records for these dates of service** ▸ _____

**I am requesting summary of care from:**

☐ Clinic visit (includes):
- imaging report
- immunizations
- lab results
- medication list
- provider note

☐ Hospital care (includes):
- lab results
- imaging report
- emergency dept. note
- discharge summary
- operative report
- history & physical

**- AND / OR -**

**Choose Individual reports**

**I only need the following individual reports/results:**

- ☐ Billing or Itemized statements
- ☐ Consult report
- ☐ Discharge summary
- ☐ Eye or Optical
- ☐ Emergency department notes
- ☐ HealthPartners Dental *(give request to your dental clinic)*
- ☐ History and physical
- ☐ Immunization record
- ☐ Lab or Pathology report
- ☐ Medication list
- ☐ Mental health records
- ☐ Operative report
- ☐ Pathology glass slides
- ☐ Provider note/clinic visit
- ☐ X-ray/Imaging report
- ☐ X-ray/Imaging CD (describe) _____
- ☐ Other _____

## Special Permissions

**In compliance with federal law, special permission is required to release the following records:**

☐ Programs for Change ☐ Alcohol and Drug Abuse Program *(ADAP)* ☐ Hutchinson SUD Program

**WISCONSIN RECORDS ONLY: Special permission is required to release the following records:**

☐ HIV test results ☐ Mental health ☐ Developmental disability ☐ Substance use disorder

## Purpose for release

☐ Continuity of care ☐ Personal/My request ☐ Disability ☐ Review current care
☐ Transfer of care ☐ Insurance ☐ Legal ☐ Other _____

## Release method

▾ Date records needed

____ /____ /____

Onsite records pickup not available; choose one of the following options

- ☐ Mail
- ☐ Fax
  - ▸ Number _____
- ☐ Release to my online account (patient portal). *Not available with all proxy access (see pg2, 7d).*
- ☐ Secure email ▸ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service.** Radiology images cannot be sent via email.*
  - ▸ Email address _____

## Authorization and Revocation

- I authorize HealthPartners to release the information marked above. HealthPartners will not withhold treatment or insurance payment based on whether I sign this form.
- Records released may include information received from other organizations.
- Records released may no longer be protected by law and could be redisclosed by the recipient. Federal regulations prohibit the recipient of substance use disorder records from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted (42.CFR.2.32).
- **There may be a charge for records.**
- This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified. ▸ _____
- I may revoke this authorization by sending a written request to the appropriate HealthPartners Release of Information department *(see section 8 on back of form)*.

| Patient signature | Date | If other than patient, state relationship and authority to sign |
|---|---|---|
| | | |

**Please review the information you have entered above. If you are satisfied with your entries, click the PRINT button at right, sign and submit the form to your clinic. If you need to make changes, click the CLEAR button at right and begin again. If you'd like to print a blank copy of the form, don't fill out the boxes and click PRINT at right.**



Print Clear

# Instructions to complete the Patient Authorization for Release of Protected Health Information

1. **Patient Information:** Complete the entire section. Print legibly and include all demographic information.


2. **Who has the information you want released?**
   - If requesting records to be sent from a HealthPartners facility, check appropriate boxes for facilities' records you want released.
   - For a description of HealthPartners, please see Notice of Privacy Practices.
   - ***External/Outside Facility section:*** If records are needed from another healthcare organization, fill this section out with as much demographic information as possible.
   - You will send this authorization to the facility listed in this section.
3. **Where do you want the information sent?**
   - Print where you want your health information sent (e.g., individual, business, other healthcare facility).
   - Include as much demographic information as possible.
   - You do not need to use an authorization to send records from one HealthPartners facility to another HealthPartners facility.
4. **Information to be sent:** In this section you will tell us what information you need. We have identified 3 categories: clinic visit/hospital care, individual documents and special permissions. You do not need to complete all 3 categories; use only those that apply to your specific need.

   Paper charts stored offsite (dates range, depending on facility) are not included in the Standard Record Set for entire/any and all requests, but they may be specifically requested and released if needed.
5. **Special Permissions:** If applicable, in this section you must specifically identify records needed by checking the appropriate box.
6. **Purpose for Release:** Indicate reason for releasing the health information. Checking this box will assist us in tracking, assigning priority and who may be responsible for the cost of records (as appropriate).
7. **Release method:** This tells us how you would like your information delivered.
   a. Entering a date ensures that your records will be available when you need them.
   b. Multiple electronic delivery options are available (e.g., email, online patient portal).
   c. If an email option is chosen, you may receive an email from the organization's copy service vendor. It will include your user information to access the requested records.
   d. Online patient portal delivery is not available in all proxy access situations. If you are a proxy for a 13-17 year old or a proxy for an adult patient, request mail, fax or secure email delivery.
8. **Authorization and Revocation**
   - Sign and date authorization. A photocopy or fax of this authorization will be treated the same as an original.
     - When requesting email delivery, be sure your email address is written VERY clearly.
     - If you are legally authorized representative, indicate your relationship to the patient on form in space provided. You may be asked to provide documents showing that you are the patient's legally authorized representative.
   - Authorization is valid for one year unless other specified.
   - Services provided after the date of signature may be released according to the authorization up until authorization expires.
   - **There may be a charge for records.**
   - To revoke the authorization, submit a written request and mail to appropriate address below. The revocation will take effect upon receipt.
   - For questions, please call the HealthPartners Family of Care Release of Information department below.
9. **HealthPartners Release of Information contact information**

**HealthPartners Release of Information**
Mailstop: 61N01I
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600 Fax 952-883-9714 or 952-883-9768

**Billing Records**

Amery Hospital & Clinics
Tel 715-268-8000 Fax 715-268-0261

HealthPartners Clinic
Tel 651-265-1999 Fax 952-883-9628

Hudson Hospital
Tel 715-531-6200 Fax 715-531-6201

Hutchinson Health
Tel 320-484-4493 Fax 952-883-3094

Lakeview Hospital
Tel 651-430-4533 Fax 651-430-8536

Olivia Hospital & Clinic
Tel 320-523-8300 Fax 320-523-8349

Park Nicollet/Methodist Hospital/TRIA
Tel 952-993-7672 Fax 952-993-7532

Regions Hospital
Tel 651-254-4791 Fax 651-254-0954

Stillwater Medical Group
Tel 651-439-1234 Fax 651-351-0827

Westfields Hospital & Clinics
Tel 715-243-2600 Fax 715-243-2786

**Radiology (images on CD)**

Amery Hospital & Clinics
Tel 715-268-0476 Fax 715-268-0481

Hudson Hospital & Clinics *(Imaging CDs)*
Tel 715-531-6230 Fax 952-883-9663
Hudson Hospital & Clinics *(Images pushed)*
Tel 715-531-6435 Fax 952-883-9727

Hutchinson Hospital & Clinics
Tel 320-484-4660 Fax 952-993-1718

Lakeview Hospital & Clinic
Tel 651-430-4615 Fax 651-430-4560

Olivia Hospital & Clinics
Tel 320-523-3464 Fax 320-523-3494

Park Nicollet/Methodist Hospital
Tel 952-993-5402 Fax 952-993-1718

Regions/HealthPartners
Tel 651-254-3794 Fax 651-254-5705

Westfields Hospital & Clinics
Tel 715-243-2730 Fax 715-243-2732

**Capitol View Transitional Care Center**
Tel 651-254-0453 Fax 651-254-0422

**Community Services**

Afton Place
Tel 651-254-0500 Fax 651-731-5847

Hovander House
Tel 651-254-4370 Fax 651-251-2190

**HP Dental**
Tel 952-883-5155 Fax 952-883-5160