

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Internal Use Only	MRN _____
	Completed by _____ Date _____
	Release ID _____

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

Patient Information	Patient name _____			Previous last name (if any) _____
	Street address _____			Date of birth _____
	City _____	State _____	ZIP code _____	Phone number _____
Who has the information you want released?	Hospital/Clinic/Healthcare Clinician _____		Phone number _____	Fax number _____
	Street address _____		City _____	State _____ ZIP code _____
Where do you want the information sent?	Person/Business/Hospital/Clinic _____		Phone number _____	Fax number _____
	Street address _____		City _____	State _____ ZIP code _____
Information to be sent (check only what applies) (see instructions on back of form)	I want health records related to this diagnosis/condition: ▶ _____			
	I want health records for these dates of service ▶ _____ <input type="checkbox"/> Clinic visit (includes provider note, lab results, imaging report, med list, immunizations) <input type="checkbox"/> Hospital care (includes emergency department note, history and physical, operative report, lab results, imaging report, discharge summary)			
	I only want individual reports/results related to this diagnosis/condition: ▶ _____			
	I only want individual reports/results checked below for these dates of service: ▶ _____ <input type="checkbox"/> Provider note/clinic visit <input type="checkbox"/> Lab or Pathology report <input type="checkbox"/> Emergency department notes <input type="checkbox"/> HealthPartners Dental <input type="checkbox"/> Operative report <input type="checkbox"/> Pathology glass slides <input type="checkbox"/> History and physical <i>(give request to your dental clinic)</i> <input type="checkbox"/> Discharge summary <input type="checkbox"/> X-ray/Imaging report <input type="checkbox"/> Consult report <input type="checkbox"/> Billing or Itemized statements <input type="checkbox"/> Eye or Optical <input type="checkbox"/> X-ray/Imaging CD (describe) <input type="checkbox"/> Immunization record <input type="checkbox"/> Other _____ <input type="checkbox"/> Medication list _____ <input type="checkbox"/> Mental health records			
Special Permissions	In compliance with federal law, special permission is required to release the following records:			
	<input type="checkbox"/> Programs for Change <input type="checkbox"/> Alcohol and Drug Abuse Program (ADAP) WISCONSIN RECORDS ONLY: Special permission is required to release the following records: <input type="checkbox"/> HIV test results <input type="checkbox"/> Mental health <input type="checkbox"/> Developmental disability <input type="checkbox"/> Substance use disorder			
Purpose for release	<input type="checkbox"/> Continuity of care <input type="checkbox"/> Personal/My request <input type="checkbox"/> Disability <input type="checkbox"/> Other _____ <input type="checkbox"/> Transfer of care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal _____			
Release method (choose one)	Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information.			
	▶ Date records needed (appointment date) ____ / ____ / ____ Paper ▶ <input type="checkbox"/> Mail Electronic ▶ <input type="checkbox"/> Secure email ▶ Indicate email address ONLY if you want your records sent via email. Email may be sent by copy service. <input type="checkbox"/> Fax ▶ Number _____ <input type="checkbox"/> Pick up ▶ Date ____ / ____ / ____ ▶ Email address _____			
Authorization and Revocation	• I authorize the HealthPartners Family of Care to release the information marked above. HealthPartners Family of Care will not withhold treatment or insurance payment based on whether I sign this form. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed. • 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. • 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). The revocation will take effect upon receipt. • A photocopy/fax of this authorization will be treated in the same way as an original.			
	Patient Signature _____			Date _____
If other than patient, state relationship and authority to sign _____				

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, see address list on bottom of page.
 - If other healthcare organization, include as much demographic information as possible.
 - You will send this authorization to the facility listed in this section.
 - For a description of HealthPartners Family of Care, please see Notice of Privacy Practices.
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. In the first 2 categories, there are 2 lines provided for you to further define the information you need. One line gives you an opportunity to tell us if you need information related to a specific diagnosis, therapy or event. The other line gives you an opportunity to tell us the specific dates of service that you need. Telling us the specific date or date range helps us gather only the information that is needed.
 - **I want my records related to...** – Complete this section if you want a summary of your office visit or hospital visit (e.g., Hip Surgery, or dates from 1/1/16 – 2/15/16). By selecting Clinic Visit and/or Hospital Care, we will disclose the documents listed in the parentheses for the specific patient care visits during the time frame you indicated. This information is typically what doctors' offices, hospitals, or other healthcare providers need in order to provide care to you.
 - **I only want individual documents...** – Complete this section if you only need or want a specific result, a range of results or a specific report document (e.g., I only want my lab and x-ray results from 1/15/16, I only want a copy of my operative report from 1/30/16, I only want physical therapy notes).
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.
 - If you have upcoming appointment *enter appointment date*. Entering a date ensures that your records will be available at your appointment.
 - If you are picking up records – check box: *I will pick up*. Enter the day on which you will pick up records.
 - Written permission is required if someone other than patient is picking up medical records, along with photo ID (e.g., driver license).
 - 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.
8. **Authorization and Revocation**
 - Sign and date authorization.
 - When picking up records in person, bring photo identification. You *will* be asked for this.
 - 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 location (see address list below).
 - For questions, please call the HealthPartners Family of Care Release of Information department below.
9. **HealthPartners Family of Care Release of Information addresses/telephone/fax information**

Amery Hospital and Clinics
 Release of Information
 265 Griffin Street East, Amery, WI 54001
 Tel 715-268-8000
 Fax 952-883-9715

Lakeview Hospital
 Release of Information
 927 Churchill Street W., Stillwater, MN 55082
 Tel 651-430-4596
 Fax 651-430-4660

Regions Hospital and Clinics
 Mail Stop 11501E - Release of Information
 640 Jackson Street, St. Paul, MN 55101
 Tel 651-254-2468
 Fax 952-883-9614

HealthPartners Central Minnesota Clinic
 Release of Information
 2251 Connecticut Ave. S., Sartell, MN 56377
 Tel 320-203-2411
 Fax 320-203-2200

**Park Nicollet/Methodist Hospital/
 TRIA Orthopaedics**
 Release of Information
 3800 Park Nicollet Blvd., St. Louis Park, MN 55416
 Tel 952-993-7600
 • If you need Park Nicollet records,
 Fax 952-883-9768
 • If you need outside records sent to Park Nicollet,
 Fax 952-993-3201

Stillwater Medical Group
 Release of Information
 1500 Curve Crest Blvd., Stillwater, MN 55082
 Tel 651-439-1234
 Fax 952-853-8725

HealthPartners Medical Clinics
 Release of Information
 MS: 11501K P.O. Box 1490
 Minneapolis, MN 55440-1490
 Tel 651-254-3100
 Fax 952-883-9714

For radiology images **only**, Mail authorization to:
 Central Film Library
 Park Nicollet Imaging Services
 3930 Louisiana Circle, St. Louis Park, MN 55426
 Tel 952-993-5427 Fax 952-993-1718

Westfields Hospital and Clinics
 Release of Information
 535 Hospital Road, New Richmond, WI 54017
 Tel 715-243-2600
 Fax 715-243-3414

Hudson Hospital and Clinics
 Release of Information
 405 Stageline Road, Hudson, WI 54016
 Tel 715-531-6230
 Fax 952-883-9663

Emergent after hours requests (5 pm - 6 am)
(health care facilities only).
 Fax completed from to: 952-993-6496

*** For HealthPartners Dental and Physicians
 Neck and Back
 authorizations, follow
 instructions given at those facilities.**

Any changes to this form must be reviewed and approved by Health Information Management.