

RELEASE OF INFORMATION – AUTHORIZATION FORM



Authorization to Release Health Information

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ Social Sec. #: _____ Phone: _____ MR# _____
Health Information Released FROM:	<input type="checkbox"/> Hennepin County Medical Center (Hospital and Clinics) <input type="checkbox"/> Hennepin County Adult Detention Center <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____
Health Information Released TO:	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____
Health Information to be Released:	<div> <div>Date of Service: _____ Type of Visit: _____</div> <div> <input type="checkbox"/> History and Physical <input type="checkbox"/> Photographs <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Radiology Images (not able to fax images) <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Progress/Clinic Notes <input type="checkbox"/> Dental Report/X-rays <input type="checkbox"/> Surgery Report <input type="checkbox"/> Care Plan <input type="checkbox"/> Visits Report <input type="checkbox"/> Medications <input type="checkbox"/> Immunizations <input type="checkbox"/> Cardiac/EKG Reports <input type="checkbox"/> Other: _____ </div> </div> <p>All information regarding alcohol/ drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:</p> <p>_____ Do Not Release Alcohol/Drug Use or Abuse records</p> <p>_____ Do Not Release Mental Health records</p> <p>_____ Do Not Release HIV/AIDS records</p>
Type of Release:	<input type="checkbox"/> Hard Copies (paper) <input type="checkbox"/> Verbal Exchange (no copies) <input type="checkbox"/> CD (requires PDF viewing capability) <input type="checkbox"/> Review of Record (no copies)
Purpose of Release:	<input type="checkbox"/> Personal <input type="checkbox"/> Attorney <input type="checkbox"/> Continued Care - Appt Date: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/ Social Security <input type="checkbox"/> Other: _____ <p style="text-align: center;">There may be a charge/fee for copies of records.</p>
Delivery Method	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick up by patient/authorized designee (requires photo ID)
Authorization/ Revocation	<p>This authorization will terminate in one year unless otherwise specified.</p> <p>I understand that I may stop this release at any time by writing to the HCMC'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 HCMC 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.</p> <div> <div> X _____ Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) </div> <div> X _____ Date </div> </div> <p>Relationship to patient (if not patient) _____</p> <p>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. A photocopy of this authorization is as valid as the original.</p>
Staff Use Only	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____

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Wenbin Ji



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