

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:	☐ Hennepin County Medical Center (Hospital and Clinics) ☐ Hennepin County Adult Detention Center ☐ 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:	<table border="0"> <tr> <td>Date of Service: _____</td><td>Type of Visit: _____</td></tr> <tr> <td>☐ History and Physical</td><td>☐ Photographs</td></tr> <tr> <td>☐ Laboratory Reports</td><td>☐ Discharge Summary</td></tr> <tr> <td>☐ Emergency Room Report</td><td>☐ Progress/Clinic Notes</td></tr> <tr> <td>☐ Surgery Report</td><td>☐ Care Plan</td></tr> <tr> <td>☐ Medications</td><td>☐ Immunizations</td></tr> <tr> <td>☐ Other: _____</td><td>☐ Radiology Reports</td></tr> <tr> <td></td><td>☐ Radiology Images (not able to fax images)</td></tr> <tr> <td></td><td>☐ Dental Report/X-rays</td></tr> <tr> <td></td><td>☐ Visits Report</td></tr> <tr> <td></td><td>☐ Cardiac/EKG Reports</td></tr> </table> 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: _____ Do Not Release Alcohol/Drug Use or Abuse records _____ Do Not Release Mental Health records _____ Do Not Release HIV/AIDS records	Date of Service: _____	Type of Visit: _____	☐ History and Physical	☐ Photographs	☐ Laboratory Reports	☐ Discharge Summary	☐ Emergency Room Report	☐ Progress/Clinic Notes	☐ Surgery Report	☐ Care Plan	☐ Medications	☐ Immunizations	☐ Other: _____	☐ Radiology Reports		☐ Radiology Images (not able to fax images)		☐ Dental Report/X-rays		☐ Visits Report		☐ Cardiac/EKG Reports
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Léo Pomar



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