

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:	Date of Service: _____ Type of Visit: _____ ☐ History and Physical ☐ Photographs ☐ Radiology Reports ☐ Laboratory Reports ☐ Discharge Summary ☐ Radiology Images (not able to fax images) ☐ Emergency Room Report ☐ Progress/Clinic Notes ☐ Dental Report/X-rays ☐ Surgery Report ☐ Care Plan ☐ Visits Report ☐ Medications ☐ Immunizations ☐ Cardiac/EKG Reports ☐ Other: _____ 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	
Type of Release:	☐ Hard Copies (paper) ☐ Verbal Exchange (no copies) ☐ CD (requires PDF viewing capability) ☐ Review of Record (no copies)	
Purpose of Release:	☐ Personal ☐ Attorney ☐ Continued Care - Appt Date: _____ ☐ Insurance ☐ Disability/ Social Security ☐ Other: _____ There may be a charge/fee for copies of records.	
Delivery Method	☐ Mail ☐ Fax ☐ Pick up by patient/authorized designee (requires photo ID)	
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 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. X _____ Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) X _____ Date Relationship to patient (if not patient) 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.	
Staff Use Only	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____	

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