

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 ☐ Laboratory Reports ☐ Emergency Room Report ☐ Surgery Report ☐ Medications ☐ Other: _____ ☐ Photographs ☐ Discharge Summary ☐ Progress/Clinic Notes ☐ Care Plan ☐ Immunizations ☐ Radiology Reports ☐ Radiology Images (not able to fax images) ☐ Dental Report/X-rays ☐ Visits Report ☐ Cardiac/EKG Reports 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	
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