

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