RELEASE OF INFORMATION - AUTHORIZATION FORM





Authorization to Release Health Information

Patient Information:	Name: Maiden Name/Alias:
HSIGHHADOV.	
	Date of Beth: 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	Person/Organization:
Released TO:	Street Address:
	City/State/Dp:
Lancas and the same of the sam	FAX: Phone:
Health Information to be Released:	Date of Service: History and Physical Photographs Radiology Reports Laboratory Reports Discharge Summary Radiology Images (not able to fax images) Surgery Report Progress/Clinic Notes Dental Report/X-rays Surgery Report Report Care Plan Suits Report Medications Dental Report Cardiac/EKG Reports Cardiac/EKG Reports
	All information regarding alcohol/ drug use or abuse, mental health and/or HTV 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	Personal Afterney Continued Care - Appt Date
Release:	Insurance Disability/ Social Security Other There may be a chargelfee 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 in 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.
	×
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Health Information	Management - Release of Information, 701 Park Ave - S7, Minneapolis, MN 55415 Phone 612-873-3179

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