Patient Authorization for Release of Protected Health Information

HealthPartners®

Internal Use Only
MRN _____
Completed by _____ Date _____
Release ID _____

Instructions for completing and mailing this form are on page 2.

Patient Information

Patient name | Previous last name (if any)
Street address | Date of birth
City | State | ZIP code | Phone number

Who has the information you want released?

Hospital/Clinic/Person | Phone number | Fax number
Street address | City | State | ZIP code

Where do you want the information sent?

Person/Business/Hospital/Clinic | Phone number | Fax number
Street address | City | State | ZIP code

Information to be sent (*check all that apply*) (*see instructions on back of form*)

I want my records related to ➤ _____

I want my records for dates of service ➤ _____ ❑ Future dates that apply to related care

❑ Clinic visit (includes provider note, lab results, imaging report, med list, immunizations)
❑ Hospital care (includes emergency dept. note, history & physical, operative report, lab results, imaging report, discharge summary)

I only want individual documents related to ➤ _____

I only want individual documents for dates of service ➤ _____ ❑ Future dates that apply to related care

❑ Provider note/clinic visit
❑ Operative Report
❑ Discharge Summary
❑ Eye or Optical
❑ Medication list
❑ Lab or Pathology report
❑ Pathology glass slides
❑ X−ray/Imagin report
❑ X−ray/Imaging CD (describe) _____
❑ Emergency department notes
❑ History and Physical
❑ Consult report
❑ Immunization
❑ Mental health record
❑ HealthPartners Dental (give request to your dental clinic)
❑ Billing or Itemized statements
➤❑ Paper ❑ CD (*Park Nicollet only*)
❑ Other _____

In compliance with federal law, special permission is requried to release the following records:
❑ Programs for Change ❑ Alcohol and Drug Abuse Program

WISCONSIN RECORDS ONLY: Special permission is required to release the following records.
❑ HIV test results ❑ Mental Health ❑ Developmental Disability ❑ Substance use disorder

Purpose for release

❑ Continuity of care ❑ Personal/My request ❑ Disability ❑ Other
❑ Transfer of care ❑ Insurance ❑ Legal _____

Release method (*choose one*)

Picture ID is required when picking up records.Written permission is required if someone other than patient is picking up information.

➤ Date records needed (appointment date) _____ / _____ / _____

Paper ➤ ❑ Mail
❑ Fax ➤ Number _____
❑ Pick up ➤ Date _____ / _____ / _____

Electronic ➤ ❑ CD
❑ Secure email ➤ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service**.*
➤ Email address _____

Authorization and Revocation

- I authorize the HealthPartners Family of Care to release the information marked above. HealthPartners Family of Care will not withhold treatment or insurance payment based on whether I sign this form. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed.
- Records released may include information received from other organizations.
- Records released may no longer be protected by law and could be redisclosed by the recipient.
- **There may be a charge for records.**
- This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified.> _____
- I may revoke this authorization by sending a written request to the appropriate HealthPartners Release of Information department (see section 8 on back of form). The revocation will take effect upon receipt.
- A photocopy/fax of this authorization will be treated in the same way as an original.

Patient signature | Date

If other than patient, state relationship and authority to sign

Any changes to this form must be reviewed and approved by Health Information Managment

Instructions to complete the Patient Authorization for Release of Protected Health Information

1. **Patient Information:** Complete the entire section. Print legibly and include all demographic information.

2. **Who has the information you want released?**
   - If requesting records to be sent from a HealthPartners facility, see address list on bottom of page.
   - If other healthcare organization, include as much demographic information as possible.
   - You will send this authorization to the facility listed in this section.
   - For a description of HealthPartners Family of Care, please see notice of privacy practices.

3. **Where do you want the information sent?**
   - Print where you want your Health Information sent (e.g. individual, business, other healthcare faclity).
   - Include as much demographic information as possible.
   - You do not need to use an authorization to send records from one HealthPartners facility to another HealthPartners facility.

4. **Information to be sent:** In this section you will tell us what information you need. We have identified 3 categories: clinic visit/hospital care, individual documents and special permissions. You do not need to complete all 3 categories; use only those that apply to your specific need. In the first 2 categories, there are 2 lines provided for you to further define the information you need. One line gives you an opportunity to tell us if you need information related to a specific diagnosis, therapy or event. The other line gives you an opportunity to tell us the specific dates of service that you need. Telling us the specific date or date range helps us gather only the information that is needed.

   - **I want my records related to...** Complete this section if you want a summary of your office visit or hospital visit (e.g., Hip Surgery, or dates from 1/1/16 2/15/16). By selecting Clinic Visit and/or Hospital Care, we will disclose the documents listed in the parentheses for the specific patient care visits during the time frame you indicated. This information is typically what doctors offi ces, hospitals, or other healthcare providers need in order to provide care to you.
   - **I only want individual documents**... Complete this section if you only need or want a specific result, a range of results or a specific report document (e.g., I only want my lab and x−ray results from 1/15/16, I only want a copy of my operative report from 1/30/16, I only want physical therapy notes).

5. **Special Permissions** If applicable, in this section you must specifically identify records needed by checking the appropriate box.

6. **Purpose for Release:** Indicate reason for releasing the health information. Checking this box will assist us in tracking, assigning priority and who may be responsible for the cost of records (as appropriate).

7. **Release method:** This tells us how you would like your information delivered.
   - If you have upcoming appointment *enter appointment date*. Entering a date ensures that your records will be available at your appointment.
   - If you are picking up records check box: I will pick up. Enter the day on which you will pick up records.
   - Written permission is required if someone other than patient is picking up medical records, along with photo ID (e.g., driver license).
   - If an email option is chosen, you may receive an email from the organization s copy service vendor. It will include your user information to access the requested records.

8. **Authorization and Revocation**
   - Sign and date authorization.
     - When picking up records in person, bring photo identification. You *will* be asked for this.
     - If you are legally authorized representative, indicate your relationship to the patient on form in space provided. You may be asked to provide documents showing that you are the patient s legally authorized representative.
   - Authorization is valid for one year unless other specified.
   - Services provided after the date of signature may be released according to the authorization up until authorization expires
   - There may be a charge for records.
   - To revoke the authorization, submit a written request and mail to appropriate location (see address list below).
   - For questions, please call the HealthPartners Family of Care Release of Information department below.

9. **HealthPartners Family of Care Release of Information addresses/telephone/fax information**

HealthPartners Medical Clinics
Release of Information
MS: 11501K
P.O. Box 1490
Minneapolis, MN 55440−1490
Tel 651−254−3100
Fax 952−883−9714

Hudson Hospital and Clinic
Release of Information
405 Stageline Road
Hudson, WI 54016
Tel 715−531−6230
Fax 715−531−6231

Regions Hospital and Clinics
Release of Information
Mail Stop 11501E
6401 Jackson Street
St. Paul, MN 55101
Tel 651−254−2468
Fax 952−883−9614

Amery Hospital and Clinic
Release of Information
265 Griffi n Street East
Amery, WI 54001
Tel 715−268−8000
Fax 715−268−0381

Lakeview Hospital
Release of Information
927 Churchill Street W.
Stillwater, MN 55082
Tel 651−430−4596
Fax 651−430−4660

Stillwater Medical Group
Release of Information
1500 Curve Crest Blvd.
Stillwater, MN 55082
Tel 651−439−1234
Fax 952−853−8725

HealthPartners Central Minnesota Clinic
Release of Information
2251 Connecticut Ave S.
Sartell, MN 56377
Tel 320−203−2411
Fax 320−203−2200

Park Nicollet/Methodist Hospital
Release of Information
3800 Park Nicollet Blvd.
St. Louis Park, MN 55416
Tel 952−993−7600
Fax 952−993−1811

Westfields Hospital and Clinic
Release of Information
535 Hospital Road
New Richmond, WI 54017
Tel 715−243−2600
Fax 715−243−3414

- **For HealthPartners Dental and Physicians Neck and Back authorizations, follow instructions given at those facilities**