Authorization for Release
of Protected Health Information

Print patient's legal name: ________________________ Birth date: ______________

Previous name(s):________________________ Phone: ______________

Patient address: ________________________

1. **Please release my records from:** *(Who has your records? Please list the specific hospitals and/or clinics. For example: Fairview, HealthEast, University of Minnesota Physicians Clinic (UMP) or other organizations.)*
   Name: ______________ Phone:__________ Fax:__________
   Address: ______________ City: __________ State:______ Zip:__________

2. **Release the records marked below for this condition or date(s) of treatment:** ______________
   (if blank, we will release 1 year's worth of most recent records.)
   All records of treatment for psychiatric/mental health, chemical dependency and AIDS/HIV-related illness or testing will be released for the dates given above unless you tell us not to release those records.
   Please specify any restrictions: ______________
   ☐Pertinent clinic records (office visit, lab/radiology results, medications, immunizations)
   ☐Pertinent hospital records (emergency, operative or discharge report, history and physical, lab/radiology results)
   ☐X-ray/Radiology films/CDs ☐X-ray/Radiology reports ☐Lab/Pathology reports ☐ *For MD only:* Pathology slides/tissue blocks ☐Immunizations ☐Emergency/Urgent Care ☐EKG/echo reports ☐History & physical ☐Progress notes ☐Diagnostic interview ☐Billing information ☐Psychological test results ☐ Psychiatric evaluation ☐Health maintenance records: latest results for DEXA, colonoscopy with any associated pathology, FIT, cologuard, immunizations, mammogram, PAP smear with HPV, chlamydia screening, ACT, PHQ-9, diabetic eye exam, last year of lab results, growth chart for pediatrics
   ☐Other - Please specify: ______________

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: ______________ Phone:__________ Fax:__________
   Address:______________ City: __________ State:______ Zip:__________

4. **Delivery/format:** ☐MyChart (patient portal) ☐ US mail ☐ CD ☐ E-mail (address: ______________)
   ☐ Fax (only for continuing care) ☐ Will pick up (**by appointment only**) **Date needed by:** __________

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other__________

6. **I understand that:**
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - My records may include records that you received from other organizations. If you have used these records and filed them in the record you maintain about me, then they may also be included in any release of information.
   - I approve the release of records for future visits, starting from the date I sign this form through:__________.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
   - This form expires one year after I sign it, or on __________, except in certain situations specified by law.

________	________	________________	________________
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and description of authority to sign for patient (may require proof)***

Directions for Completing the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Please print. Please note that blank items on this form may cause major delays in processing your request. Complete this form as fully as possible. Allow a minimum of 10 business days for processing.

Patient Information section: This is about the patient who needs medical records. Please fill it out completely.

Section 1 - Release records from: Write down which clinic, hospital or facility has the medical records.

Section 2 - Records to be released *(Important: If the information you identify includes sensitive information you do not want to release, you can exclude that information in section 6.):*

- **For condition or dates of treatment:** Write down the condition or dates of treatment.
- Mark the box next to the information you want released. Check "other" to request any records not listed. Please specify which records you need.

Section 3 - Please release my records to: Write down your name or the name of another person, healthcare facility or organization that needs the medical records. (Please note: it is Fairview's policy NOT to fax or e-mail patient information except for direct patient care needs or by patient request, such as to a hospital or clinic.)

Section 4 - Delivery/format: Mark how you would like the records to be prepared and delivered. The patient portal is a secure electronic delivery option for patients who provide their personal e-mail address.

Section 5 - Purpose: Mark why you need a copy of the records. This will help track your request and assign priority status, if needed. It also informs us who may be responsible for the cost of records (when appropriate).

Section 6 – I understand: Read the bulleted items. This consent will expire (end) in 12 months unless you write in a different date. You may **stop** or **revoke** (take back) your consent by writing us. Sign and date the form and include the time. If you are signing the document on behalf of the patient, proof of your legal authority may be requested. Proof examples: Power Of Attorney (POA) for Healthcare, Advance Care Directive, or court-appointed Legal Guardianship documents.

Use this form to release records from any HealthEast location, or any of these listed Fairview places: Fairview Facilities.

Contact Information for Release of Information:

University of Minnesota Medical Center & University of Minnesota Masonic Children's Hospital

& University of Minnesota Health Clinics and Surgery Center / Fairview Metro Area Hospitals / Fairview Metro Area Clinics
2450 Riverside Ave.

Minneapolis, MN 55454

Email: releaseofinformation@fairview.org

Phone: 952-924-5165
Fax: 952-915-8824

Fairview Range
Health Information Management
750 East 34th Street
Hibbing, MN 55746
Phone: 218-362-6627
Fax: 218-362-6678

Grand Itasca Clinic & Hospital
1601 Golf Course Road,
Grand Rapids MN 55744
Phone: 218-326-3401
Fax: 218-999-1513

HealthEast
Release of Information
1690 University Ave. Suite 180
St. Paul, MN 55104
Email:
releaseofinformation@healtheast.org
Phone: 651-232-4999
Fax: 651-232-4887

For other locations, please visit http://www.fairview.org or www.healtheast.org.

INFORMATIONAL PAGE ONLY