University of Minnesota Authorization for Release of Information

1 Patient information

First name ______________ Middle name ______________ Last name ______________

Patient date of birth ___ /___ / ______ (MM DD YYYY) Previous name(s) ______________

Home address ______________

City ______________ State ________ Zip code ______________

Daytime phone ______________ E-mail address (optional) ______________

Medical Record/patient ID number (optional) ______________

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name ______________ Last name ______________ about how this form was completed,

this person can be reached at: Daytime phone ______________ E-mail address (optional) ______________

3 I am requesting health information be released from at least one of the following:

Organization(s) name ______________

Specific health care facility or location(s) ______________

Specific health care professional's name(s) ______________

4 I am requesting that health information be sent to:

Organization(s) name ______________

And/or person: First name ______________ Last name ______________

Mailing address ______________

City ______________ State ________ Zip code ______________

Phone (optional) ______________ Fax (optional) ______________

Information needed by (date) ___ / ___ / ______ (MM DD YYYY) (optional)

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment ______________

☐ All health information

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical
☐ Laboratory report
☐ Emergency room report
☐ Surgical report
☐ Medications
☐ Mental health
☐ Discharge summary
☐ Progress notes
☐ Care plan
☐ Immunizations
☐ HIV/AIDS testing
☐ Radiology report
☐ Radiology image(s)
☐ Photographs, video, digital or other images
☐ Billing records
☐ Other information or instructions ______________

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program

☐ Psychotherapy notes *(this consent cannot be combined with any other)*

University of Minnesota Authorization for Release of Information

Patient's name ______________________________

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _______

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount______________)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) ______________________________

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, 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 if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / ______ (MM / DD / YYYY) Or specific event ______________________________

9 Patient's signature

Patient's signature ______________________________ Date ___ / ___ / ______ (MM / DD / YYYY)

OR legally authorized representative's signature ______________________________ Date ___ / ___ / ______ (MM / DD / YYYY)

Representative's relationship to patient (parent, guardian, etc.) ______________________________