



Hennepin County Medical Center



701 Park Ave S – RL.200
Minneapolis, MN 55415
612-873-3179 – phone
612-904-4246 – fax

Release of Information Authorization

Section 1:

First Name	Middle Name	Last Name
Street Address		Date of Birth ____ / ____ / ____ Month Date Year
City	State and Zip	Phone
Any previous names or aliases		MRN

Section 2:

I give my permission for (please check all that apply):

- Hennepin County Medical Center, this includes (please cross off any you do not want included on this release):
 - Hennepin Care - North
 - Hennepin Care - South
 - Hennepin Care - East Lake
 - Family Medical Center
 - Wal-Mart Bloomington Clinic
- Hennepin County Adult Correctional Facility

Section 3:

- To release my information to the following organization
- To obtain information from the following organization

Section 4:

Organization:	OR	Person – First Name	Person – Last Name
Mailing Address:			
City	State	Zip	
Fax Number (optional):		Phone Number (optional):	

Section 5:

Method of transfer:

- Mail
- Fax (Continued Care purpose only - must include fax number above)
- Pick-up (must present valid ID)

Section 6:

The information release from my medical records should include:

Specific Dates of Service or Time Frame: _____

OR

Specific Clinic or Physician Records: _____

OR

Specific Portions of your health record:

- | | | |
|--|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Photographs/digital images | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Progress/Clinic Notes | <input type="checkbox"/> Dental Reports |
| <input type="checkbox"/> Surgery Report | <input type="checkbox"/> Care Plan | <input type="checkbox"/> Dental x-rays |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Encounters Report |
| <input type="checkbox"/> Other: _____ | | |

PLEASE SEE BACK SIDE FOR ADDITIONAL INFORMATION AND REQUIRED SIGNATURE LINE

180-00489 (2/10)

Section 7:

THE FOLLOWING ITEMS REQUIRE SPECIAL CONSENT (please check any that may be part of your record – if there is mention of these items within your record and the appropriate box is not checked there may be a delay in processing your request) :

- Drug and/or Alcohol Information (includes treatment for or while intoxicated)
- Mental Health or Psychiatric Information
- HIV/AIDS

Section 8:

Verbal Release/Communications:

You may want to authorize a friend or family member to have conversations with your health care provider. In order for this to take place the following needs to be completed with the friend or family member’s name and the health care provider’s name (You may list HCMC if any health care provider is allowed to speak with your friend or family.)

The following authorizes _____ to have verbal communication
(Name of person authorized to speak to your health care provider)
with _____.
(Name of health care provider or organization)

Section 9:

Reason for Release:

Please provide us information on the purpose of this release (check all that apply):

- Patient
- Attorney
- Social Security
- Continued care
- Disability
- Insurance
- Other: _____

Section 10:

I would like to receive my information in the following format (please only check one):

- Paper (if one is not selected paper is the default format)
- CD

Section 11:

I understand that by signing this form, I am requesting that the health information specified be sent to the third party named in the ‘release to’ section of the form.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) name in ‘release from’ section of the form. If the organization, facility or professional named 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 is sent to the third party named in the form 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 is a health care provider they will not condition my 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 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 ____/____/____ or a specific event _____
Month Date Year

Signature – Required for the request to be processed:

Patient Signature

Date Signed

OR

Parent/Legally Authorized Representative*

Relationship to the Patient

Date Signed

* You may be required to present documentation that authorizes you to have access to the patient’s information.