



Patient Authorization for Release of Protected Health Information



AUTHR

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) _____		Phone number _____	
	Street address _____		City _____		State _____	ZIP code _____ Date of birth _____
Release my records from:	<input type="checkbox"/> Amery Hospital & Clinics		<input type="checkbox"/> Hutchinson Health Hospital & Clinics		<input type="checkbox"/> Park Nicollet Clinics/TRIA: location _____	
	<input type="checkbox"/> HealthPartners Central MN Clinic		<input type="checkbox"/> Lakeview Hospital		<input type="checkbox"/> Regions Hospital & Clinics	
	<input type="checkbox"/> HealthPartners Medical Clinics: location _____		<input type="checkbox"/> Methodist Hospital		<input type="checkbox"/> Stillwater Medical Group	
<input type="checkbox"/> Hudson Hospital & Clinics		<input type="checkbox"/> Olivia Hospital & Clinic		<input type="checkbox"/> Westfields Hospital & Clinics		
<input type="checkbox"/> External/Outside facility (complete this section only if requesting outside records)			Phone number _____		Fax number _____	
Street address _____			City _____		State _____	ZIP code _____
Send my records to:	Person/Business/Hospital/Clinic _____		Phone number _____		Fax number _____	
	Street address _____		City _____		State _____	ZIP code _____
Information to be released <i>• check only what applies</i> <i>• there may be a charge for records</i> <i>• instructions on back of form</i>	I want health records related to this diagnosis/condition ▶ _____					
	I want health records for these dates of service ▶ _____					
	I am requesting summary of care from:		I only need the following individual reports/results:			
<input type="checkbox"/> Clinic visit (includes):		<input type="checkbox"/> Billing or Itemized statements		<input type="checkbox"/> Lab or Pathology report		
· imaging report · medication list		<input type="checkbox"/> Consult report		<input type="checkbox"/> Medication list		
· immunizations · provider note		<input type="checkbox"/> Discharge summary		<input type="checkbox"/> Mental health records		
· lab results		<input type="checkbox"/> Eye or Optical		<input type="checkbox"/> Operative report		
<input type="checkbox"/> Hospital care (includes):		<input type="checkbox"/> Emergency department notes		<input type="checkbox"/> Pathology glass slides		
· lab results · operative report		<input type="checkbox"/> HealthPartners Dental		<input type="checkbox"/> Provider note/clinic visit		
· imaging report · history & physical		<i>(give request to your dental clinic)</i>		<input type="checkbox"/> X-ray/Imaging report		
· emergency dept. note		<input type="checkbox"/> History and physical		<input type="checkbox"/> X-ray/Imaging CD (describe) _____		
· discharge summary		<input type="checkbox"/> Immunization record		<input type="checkbox"/> Other _____		
Special Permissions	In compliance with federal law, special permission is required to release the following records:					
	<input type="checkbox"/> Programs for Change		<input type="checkbox"/> Alcohol and Drug Abuse Program (ADAP)			
WISCONSIN RECORDS ONLY: Special permission is required to release the following records:						
<input type="checkbox"/> HIV test results		<input type="checkbox"/> Mental health		<input type="checkbox"/> Substance use disorder		
Purpose for release	<input type="checkbox"/> Continuity of care		<input type="checkbox"/> Personal/My request		<input type="checkbox"/> Disability	
	<input type="checkbox"/> Transfer of care		<input type="checkbox"/> Insurance		<input type="checkbox"/> Legal _____	
Release method (choose one)	▶ Date records needed ____ / ____ / ____					
	Paper ▶ <input type="checkbox"/> Mail			Electronic ▶ <input type="checkbox"/> Secure email ▶		
	<input type="checkbox"/> Fax ▶ Number _____			▶ Email address _____		
<input type="checkbox"/> Release to myChart (patient portal)						
Authorization and Revocation	<ul style="list-style-type: none"> 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 _____	

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, check appropriate boxes for facilities' records you want released.
 - For a description of HealthPartners Family of Care, please see Notice of Privacy Practices.
 - **External/Outside Facility section:** If records are needed from another healthcare organization, fill this section out with as much demographic information as possible.
 - You will send this authorization to the facility listed in this section.
- 3. Where do you want the information sent?**
 - Print where you want your health information sent (e.g., individual, business, other healthcare facility).
 - 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.

Paper charts stored offsite (dates range, depending on facility) are not included in the Standard Record Set for entire/any and all requests, but they may be specifically requested and released if needed.
- 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.
 - Entering a date ensures that your records will be available when you need them.
 - Multiple electronic delivery options are available (e.g., email, myChart).
 - 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 requesting email delivery, be sure your email address is written VERY clearly.
 - 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**

Amery Hospital and Clinic

Release of Information (*office located at Westfields*)
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3501
Fax 952-883-9731

HealthPartners Medical Clinics

Release of Information
Mailstop: 61N011
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9714

Hudson Hospital and Clinic

Release of Information
405 Stageline Road, Hudson, WI 54016
Tel 715-531-6230
Fax 952-883-9663

Hutchinson Health Hospital & Clinics

Release of Information
1095 Hwy. 15 South, Hutchinson, MN 55350
Tel 320-484-4525
Fax 952-883-3084

Lakeview Hospital/Stillwater Medical Group

Release of Information
927 Churchill Street W., Stillwater, MN 55082
Tel 651-430-4596
Fax 952-883-9798

Olivia Hospital and Clinic

Release of Information
100 Healthy Way, Olivia, MN 56277
Tel 320-523-8303
Fax 952-883-9670

Park Nicollet/Methodist Hospital/ TRIA Orthopaedics

Release of Information
Mailstop: 61N011
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9768

Regions Hospital and Clinics

Release of Information
Mailstop: 61N011
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9614

Westfields Hospital and Clinic

Release of Information
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3406
Fax 952-883-9729

For facilities below, follow their instructions:

Capitol View Transitional Care Center Tel 651-254-0453 Fax 651-254-0422

Community Services

Afton Place	Tel 651-254-0500	Fax 651-731-5847
Hovander House	Tel 651-254-4370	Fax 651-251-2190
Safe House	Tel 651-254-4744	Fax 651-726-2470

HP Dental Tel 952-883-5155 Fax 952-883-5160

Home Healthcare & Hospice Tel 952-883-6875 Fax 952-883-9779

Billing Records

HealthPartners Clinic	Tel 651-265-1999	Fax 952-883-9628
Regions Hospital	Tel 651-254-4791	Fax 651-254-0954
Park Nicollet/Methodist Hospital/TRIA	Tel 952-993-7672	Fax 952-993-7532

Radiology (images on CD)

Regions/HealthPartners	Tel 651-254-3794	Fax 651-254-5705
Park Nicollet/Methodist Hospital	Tel 952-993-5402	Fax 952-993-1718
Westfields Hospital	Tel 715-243-2730	Fax N/A