Regions Hospital

HealthPartners®

Regions Hospital Use Only
MRN_____
Release ID_____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	Patient Name _____ Patient Former Name_____ Date of Birth _____ Patient Phone (_____)_____ − _____ Address_____ City _____ State _____ Zip _____
Health Information Released FROM	☐ Regions Hospital and Regions Clinics ☐ Other _____ 　　　Address_____ City _____ State _____ Zip _____
Health Information Released TO	Individual Name _____ Phone (_____) _____ Organization Name _____ Fax # (_____) _____ Address_____ City _____ State _____ Zip _____
Purpose of Disclosure	☐ Continuity of Care　　☐ Insurance　　☐ Personal ☐ Disability　　　　　　☐ Legal/Attorney　　☐ Other (Please Explain) _____
Health Information to be Released	☐ **Copies of Records**　　☐ **Verbal Exchange (no copies)** ☐ Entire Health Record (initial here) _____ ☐ Hospital admission (date) _____　☐ Emergency room visit (date) _____　☐ Clinic Visit (date)_____ ☐ History and physical report　　☐ Laboratory results　　☐ Consultation Report ☐ Procedure / operative report　　☐ X−ray / imaging results　　☐ Discharge summary ☐ Medication administration report　　☐ Radiology image film / CD　　☐ Discharge instructions ☐ Other (described here) _____ *Unless specifically excluded, behavioral health/mental health information and/or HIV information appearing in the information selected above will be disclosed. Please exclude:*_____ If initialed here _____, my chemical health treatment program record may be disclosed.
Method of Delivery	☐ Mail to Recipient　　　　　　　☐ Pick up on _____/_____/_____ (photo ID required at pick−up) ☐ Fax to: _____　　　　☐ Other: _____
Authorization	**This authorization expires (ends) on the following date, event or condition:** _____ This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law. **I understand that:** • I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in Section 1 above. • Revoking this authorization does not apply to information that has already been released under this authorization. • I have the right to inspect or obtain a copy of the health information to be disclosed. • If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may <u>not</u> be protected by state or federal privacy laws and may be re−disclosed. • I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company. _____　　　_____　_____ *Signature of Patient or Patient's Representative*　　　*Signature Date*　　*Time* If signed by patient's representative: _____　　　_____ *Print name of representative*　　　　　　*Relationship to patient* _____　　　_____ *Signature of Witness*　　　　　　　　　*Print name of witness*