## Patient Authorization for Release of Protected Health Information

**Instructions for completing and mailing this form are on page 2.**

### Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td></td>
</tr>
<tr>
<td>Previous last name (if any)</td>
<td></td>
</tr>
<tr>
<td>Street address</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>ZIP code</td>
<td></td>
</tr>
<tr>
<td>Phone number</td>
<td></td>
</tr>
</tbody>
</table>

### Who has the information you want released?

**Hospital/Clinic/Healthcare Clinician**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td></td>
</tr>
<tr>
<td>Phone number</td>
<td></td>
</tr>
<tr>
<td>Fax number</td>
<td></td>
</tr>
</tbody>
</table>

**Person/Business/Hospital/Clinic**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Street address</td>
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<tr>
<td>Phone number</td>
<td></td>
</tr>
<tr>
<td>Fax number</td>
<td></td>
</tr>
</tbody>
</table>

### Where do you want the information sent?

**Information to be sent**

(check only what applies)

- [ ] I want health records related to this diagnosis/condition
- [ ] I want health records for these dates of service
- [ ] I only want _individual_ reports/results related to this diagnosis/condition
- [ ] I only want _individual_ reports/results checked below for these dates of service

**Special Permissions**

In compliance with federal law, special permission is required to release the following records:

- [ ] Programs for Change
- [ ] Alcohol and Drug Abuse Program (ADAP)
- [ ] HIV test results
- [ ] Mental health
- [ ] Developmental disability
- [ ] Substance use disorder

### Purpose for release

- [ ] Continuity of care
- [ ] Personal/My request
- [ ] Disability
- [ ] Other
- [ ] Transfer of care
- [ ] Insurance
- [ ] Legal

### Release method (choose one)

- [ ] Paper
- [ ] Mail
- [ ] Fax
- [ ] Electronic
- [ ] Secure email
- [ ] Indicate email address ONLY if you want your records sent via email. *Email may be sent by copy service.*

### Authorization and Revocation

- [ ] 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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

If other than patient, state relationship and authority to sign.

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Any changes to this form must be reviewed and approved by Health Information Management. 18534 (4/2019)
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, see address list on bottom of page.
   - If other healthcare organization, include as much demographic information as possible.
   - You will send this authorization to the facility listed in this section.
   - For a description of HealthPartners Family of Care, please see Notice of Privacy Practices.

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. In the first 2 categories, there are 2 lines provided for you to further define the information you need. One line gives you an opportunity to tell us if you need information related to a specific diagnosis, therapy or event. The other line gives you an opportunity to tell us the specific dates of service that you need. Telling us the specific date or date range helps us gather only the information that is needed.
   - **I want my records related to...** – Complete this section if you want a summary of your office visit or hospital visit (e.g., Hip Surgery, or dates from 1/1/16 – 2/15/16). By selecting Clinic Visit and/or Hospital Care, we will disclose the documents listed in the parentheses for the specific patient care visits during the time frame you indicated. This information is typically what doctors’ offices, hospitals, or other healthcare providers need in order to provide care to you.
   - **I only want individual documents...** – Complete this section if you only need or want a specific result, a range of results or a specific report document (e.g., I only want my lab and x-ray results from 1/15/16, I only want a copy of my operative report from 1/30/16, I only want physical therapy notes).

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.
   - If you have upcoming appointment enter appointment date. Entering a date ensures that your records will be available at your appointment.
   - If you are picking up records – check box: I will pick up. Enter the day on which you will pick up records.
   - Written permission is required if someone other than patient is picking up medical records, along with photo ID (e.g., driver license).
   - 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 picking up records in person, bring photo identification. You will be asked for this.
   - 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 otherwise 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
     - 265 Griffin Street East, Amery, WI 54001
     - Tel 715-268-8000
     - Fax 952-883-9175

   - **HealthPartners Central Minnesota Clinic**
     - Release of Information
     - 2251 Connecticut Ave. S., Sartell, MN 56377
     - Tel 320-203-2411
     - Fax 320-203-2200

   - **HealthPartners Medical Clinics**
     - Release of Information
     - MS: 11501K
     - P.O. Box 1490, Minneapolis, MN 55440-1490
     - Tel 612-234-3100
     - Fax 952-883-9174

   - **Lakeview Hospital**
     - Release of Information
     - 927 Churchill Street W., Stillwater, MN 55082
     - Tel 651-430-4596
     - Fax 651-430-4660

   - **Lakewood Hospital**
     - Release of Information
     - 3930 Louisiana Circle, St. Louis Park, MN 55426
     - Tel 952-993-6496
     - Fax 952-993-3201

   - **Lakeview Hospital**
     - Release of Information
     - 265 Griffin Street East, Amery, WI 54001
     - Tel 715-268-8000
     - Fax 952-883-9175

   - **Park Nicollet/Methodist Hospital/TRIA Orthopaedics**
     - Release of Information
     - 3800 Park Nicollet Blvd., St. Louis Park, MN 55416
     - Tel 952-993-7600
     - Fax 952-883-9768
     - If you need Park Nicollet records, fax 952-883-3201

   - **Park Nicollet Imaging Services**
     - For radiology images only, mail authorization to:
       - Central Film Library
       - Park Nicollet Imaging Services
       - 3930 Louisiana Circle, St. Louis Park, MN 55426
       - Tel 952-993-5402 • Fax 952-993-1718

   - **Regions Hospital and Clinics**
     - Mail Stop 11501E - Release of Information
     - 640 Jackson Street, St. Paul, MN 55101
     - Tel 651-254-2468
     - Fax 952-883-9614

   - **Stillwater Medical Group**
     - Release of Information
     - 1900 Curve Crest Blvd., Stillwater, MN 55082
     - Tel 651-439-1234
     - Fax 952-853-8725

   - **Westfields Hospital and Clinic**
     - Release of Information
     - 535 Hospital Road, New Richmond, WI 54017
     - Tel 715-243-2600
     - Fax 715-243-3414

* For HealthPartners Dental and Physicians Neck and Back authorizations, follow instructions given at those facilities.