



AUTHR

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| 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) _____ | |
| | Street address _____ | | | Date of birth _____ | |
| | City _____ | State _____ | ZIP code _____ | Phone number _____ | |
| Who has the information you want released? | Hospital/Clinic/Healthcare Clinician _____ | | Phone number _____ | | Fax number _____ |
| | Street address _____ | | City _____ | State _____ | ZIP code _____ |
| Where do you want the information sent? | Person/Business/Hospital/Clinic _____ | | Phone number _____ | | Fax number _____ |
| | Street address _____ | | City _____ | State _____ | ZIP code _____ |
| Information you want sent (check only what applies) (see instructions on back of form) | I want health records related to this diagnosis/condition ▶ _____ | | | | |
| | I want health records for these dates of service ▶ _____ | | | | |
| | <input type="checkbox"/> Clinic visit (includes provider note, lab results, imaging report, med list, immunizations) <input type="checkbox"/> Hospital care (includes emergency department note, history and physical, operative report, lab results, imaging report, discharge summary) | | | | |
| | I only want individual reports/results related to this diagnosis/condition ▶ _____ | | | | |
| | I only want individual reports/results checked below for these dates of service ▶ _____ | | | | |
| | <input type="checkbox"/> Provider note/clinic visit | <input type="checkbox"/> Lab or Pathology report | <input type="checkbox"/> Emergency department notes | <input type="checkbox"/> HealthPartners Dental <i>(give request to your dental clinic)</i> | |
| | <input type="checkbox"/> Operative report | <input type="checkbox"/> Pathology glass slides | <input type="checkbox"/> History and physical | <input type="checkbox"/> Billing or Itemized statements | |
| | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> X-ray/Imaging report | <input type="checkbox"/> Consult report | | |
| <input type="checkbox"/> Eye or Optical | <input type="checkbox"/> X-ray/Imaging CD (describe) _____ | <input type="checkbox"/> Immunization record | | | |
| <input type="checkbox"/> Medication list | | <input type="checkbox"/> Mental health records | <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"/> Developmental disability <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"/> Other _____ | |
| | <input type="checkbox"/> Transfer of care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal | | |
| Release method (choose one) | Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information. | | | | |
| | ▶ Date records needed (appointment date) ____ / ____ / ____ | | | | |
| | Paper ▶ <input type="checkbox"/> Mail <input type="checkbox"/> Fax ▶ Number _____ <input type="checkbox"/> Release to myChart (patient portal) | | Electronic ▶ <input type="checkbox"/> Secure email ▶ _____ ▶ Email address _____ | | |
| 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. | | | | |
| | 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, 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.
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.
 - If you have upcoming appointment *enter appointment date*. Entering a date ensures that your records will be available at your appointment.
 - 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 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

Physicians Neck and Back Tel 651-631-4242 Fax 952-883-9768

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 |