HealthPartners®

# 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) |
|---|---|---|---|
| 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** ▶ ______

- ☐ Clinic visit (includes provider note, lab results, imaging report, med list, immunizations)
- ☐ 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** ▶ ______

- ☐ Provider note/clinic visit
- ☐ Operative report
- ☐ Discharge summary
- ☐ Eye or Optical
- ☐ Medication list
- ☐ Lab or Pathology report
- ☐ Pathology glass slides
- ☐ X-ray/Imaging report
- ☐ X-ray/Imaging CD (describe) ______
- ☐ Emergency department notes
- ☐ History and physical
- ☐ Consult report
- ☐ Immunization record
- ☐ Mental health records
- ☐ HealthPartners Dental *(give request to your dental clinic)*
- ☐ Billing or Itemized statements
- ☐ Other ______

**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)*

**WISCONSIN RECORDS ONLY: Special permission is required to release the following records:**

- ☐ HIV test results
- ☐ Mental health
- ☐ Developmental disability
- ☐ Substance use disorder

**Purpose for release**

- ☐ Continuity of care
- ☐ Transfer of care
- ☐ Personal/My request
- ☐ Insurance
- ☐ Disability
- ☐ Legal
- ☐ Other ______

**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** ▶ ☐ Mail
☐ Fax ▶ Number ______
☐ Release to myChart (patient portal)

**Electronic** ▶ ☐ Secure email ▶ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service.** Radiology images cannot be sent via 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
MS: 11501K
P.O. Box 1490, Minneapolis, MN 55440-1490
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 320-484-4684

**Lakeview Hospital/Stillwater Medical Group**
Release of Information
927 Churchill Street W., Stillwater, MN 55082
Tel 651-430-4596
Fax 952-883-9798

**Park Nicollet/Methodist Hospital/ TRIA Orthopaedics**
Release of Information
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9768

**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

**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 |