



AUTHR

Patient Authorization for Release of Protected Health Information

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 • check only what applies • there may be a charge for records • instructions on back of form	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): <ul style="list-style-type: none">• imaging report• immunizations• lab results• medication list• provider note		<input type="checkbox"/> Billing or Itemized statements <input type="checkbox"/> Consult report <input type="checkbox"/> Discharge summary <input type="checkbox"/> Eye or Optical <input type="checkbox"/> Emergency department notes <input type="checkbox"/> HealthPartners Dental (give request to your dental clinic) <input type="checkbox"/> History and physical <input type="checkbox"/> Immunization record			
<input type="checkbox"/> Hospital care (includes): <ul style="list-style-type: none">• lab results• imaging report• emergency dept. note• discharge summary• operative report• history & physical		<input type="checkbox"/> Lab or Pathology report <input type="checkbox"/> Medication list <input type="checkbox"/> Mental health records <input type="checkbox"/> Operative report <input type="checkbox"/> Pathology glass slides <input type="checkbox"/> Provider note/clinic visit <input type="checkbox"/> X-ray/Imaging report <input type="checkbox"/> X-ray/Imaging CD (describe) _____ <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) <input type="checkbox"/> Hutchinson SUD Program					
	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"/> Transfer of care		<input type="checkbox"/> Insurance		<input type="checkbox"/> Legal	
Release method (choose one)	▼ Date records needed ____ / ____ / ____		<input type="checkbox"/> Mail			
			<input type="checkbox"/> Fax			
			<input type="checkbox"/> Release to my online account (patient portal). Not available with all proxy access (see pg2, 7d).			
			<input type="checkbox"/> 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 HealthPartners to release the information marked above. HealthPartners will not withhold treatment or insurance payment based on whether I sign this form.					
	• 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. Federal regulations prohibit the recipient of substance use disorder records from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted (42.CFR.2.32).					
	• 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).					
	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.
 - a. Entering a date ensures that your records will be available when you need them.
 - b. Multiple electronic delivery options are available (e.g., email, online patient portal).
 - c. 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.
 - d. Online patient portal delivery is not available in all proxy access situations. If you are a proxy for a 13-17 year old or a proxy for an adult patient, request mail, fax or secure email delivery.
- 8. Authorization and Revocation**
 - Sign and date authorization. A photocopy or fax of this authorization will be treated the same as an original.
 - 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 address below. The revocation will take effect upon receipt.
 - 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
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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