

**Authorization for Release
of Protected Health Information**



Office use only MR# _____

Print patient's legal name: _____ **Birth date:** _____
Previous name(s): _____ **Phone:** _____

1. Please release my records from: *(Who has your records? Please list the specific hospital and/or clinic.)*

Name: _____
Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

2. Release the records marked below for this condition or date(s) of treatment: _____
(if blank, we will release 1 years' worth of most recent records.)

- Pertinent Clinic Record Set (office visit, lab/radiology, medications, immunizations)
- Pertinent Hospital Record Set (emergency, operative or discharge report, history and physical, lab/radiology)
- Immunization records X-ray/Radiology films/CDs Emergency/Urgent Care reports EKG/ECHO Reports
- Lab/Pathology reports X-ray/Radiology Reports *For MD only:* Pathology slides/tissue blocks
- Other (please specify): _____

3. Please release my records to: *(Who needs your records? Where do you want the information sent?)*

Name: _____
Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

4. Delivery/format: Paper copy CD Mail Fax Will pick up _____
 E-mail and/or patient portal address: _____ **Date needed by:** _____

5. Purpose: Continuing care Insurance Personal use Disability Legal Other _____

6. I understand that:

- Except for psychotherapy notes (not included in medical record), the release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released:** _____
- If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
- Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- I approve the release of records for future visits, starting from the date I sign this form through: _____.
- There may be a fee for releasing these records.
- A photocopy of this completed, signed form is considered valid if not altered.
- If I do not sign this form, I will still get medical treatment, unless treatment is part of a research project.
- This form expires one year after I sign it, or on _____, except in certain situations specified by law.

Date	Time	Signature of patient or authorized person	If authorized person, print name and description of authority to sign for patient (may require proof)
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Directions for Completing the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Use clear handwriting.

Patient Information section: This is about the patient who needs medical records. Please fill it out completely.

Section 1 - Release records from: Write down which clinic, hospital or facility has the medical records.

Section 2 - Records to be released (*Important: If the information you identify includes sensitive information you do not want to release, you can exclude that information in section 6.*):

- **For condition or dates of treatment:** Write down the condition or dates of treatment.
- Mark the box next to the information you want released. Check “other” to request any records not listed. Please specify which records you need.

Section 3 - Please release my records to: Write down your name or the name of another person, healthcare facility or organization that needs the medical records. (Please note: it is Fairview’s policy NOT to fax or e-mail patient information except for direct patient care needs or by patient request, such as to a hospital or clinic.)

Section 4 - Delivery/format: Mark how you would like the records to be prepared and delivered. The patient portal is a secure electronic delivery option for patients who provide their personal e-mail address. For additional questions, call 763-852-8850.

Section 5 - Purpose: Mark why you need a copy of the records. This will help track your request and assign priority status, if needed. It also informs us who may be responsible for the cost of records (when appropriate).

Section 6 – I understand: Read the bulleted items. This consent will expire (end) in 12 months unless you write in a different date. You may **stop** or **revoke** (take back) your consent by writing us. Sign and date the form, and include the time. If you are signing the document on behalf of the patient, proof of your legal authority may be requested. Proof examples: Power Of Attorney (POA) for Healthcare, Advance Care Directive and court appointed Legal Guardianship documents.

Contact Information for Release of Information:

Fairview Clinics
Health Information Management
4000 Central Ave.
Columbia Heights, MN 55421
Phone: 763-852-8850
Fax 612-365-0304

Fairview Northland Medical Center
Health Information Management
911 Northland Dr.
Princeton, MN 55371
Phone: 763-389-6573
Fax: 763-389-6545

Fairview Ridges Hospital
Health Information Management
201 East Nicollet Blvd.
Burnsville, MN 55337
Phone: 952-892-2060
Fax: 952-892-2024

Fairview Lakes Medical Center
Health Information Management
5200 Fairview Blvd.
Wyoming, MN 55092
Phone: 651-982-7870
Fax: 651-982-7122

Fairview Range
Health Information Management
750 East 34th Street
Hibbing, MN 55746
Phone: 218-362-6627
Fax 218-362-6678

Fairview Southdale Hospital
Release of Information, LL25
6401 France Ave. S.
Edina, MN 55435-2199
Phone: 952-924-1414
Fax: 952-924-8443

University of Minnesota Medical Center & University of Minnesota Masonic Children's Hospital & University of Minnesota Health Clinics and Surgery Center

West Bank campus
Release of Information, F-108 West Bldg.
2450 Riverside Ave.
Minneapolis, MN 55454
Phone: 612-273-4359
Fax: 612-273-4069

For other locations, please visit www.fairview.org/medicalrecords.