Gillette Children's
Specialty Healthcare

Health Information Services
200 University Ave. E.
St. Paul, MN 55101
Phone: 651-312-3122
Fax: 651-229-3888

AUTHORIZATION TO RELEASE INFORMATION

1. You must clearly complete all items in this document marked with an asterisk (*). See back of form for more information.

Medical Record Number (supplied by Gillette):_____

* Patient Name: _____ *Patient Date of Birth: _____

2. Check one of the following boxes.

☐ I authorize Gillette to communicate verbally and release my documents to the person or organization below.
☐ I authorize Gillette to communicate verbally only. I DO NOT authorize Gillette to release copies of documents.
☐ I authorize the Facility/person below to release copies of documents to _____ at Gillette Children's Specialty Healthcare.

3. Complete this section to authorize release information to/from this person or organization.

*Name:_____

*Facility:_____

*Address:_____

*City: _____ *State: _____ *Zip Code:_____

*Phone:_____ FAX (if known): _____

4. For what dates can we release information? (Start date): _____ (End date): _____

5. What information can we release? Mark the items that apply in 5a, 5b, and 5c.

5a. PERTINENT INFORMATION

☐ I authorize the release of **all items** in this box.

To authorize the release of only specific items, select them below and **do not** mark the box above.

- ☐ Discharge Summary
- ☐ Operative Report(s)
- ☐ History & Physical Exam
- ☐ Outpatient Clinic Notes
- ☐ Imaging Reports (**reports ONLY**, does **not** include images)
- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Consultation Report(s)
- ☐ Special Testing

5b. NONPERTINENT INFORMATION

I authorize the release of the items marked in this box.

- ☐ Imaging Exam(s) – (Radiology exams, such as X-rays, CTs, MRIs, and ultrasounds)
- ☐ Media (photos, videos, and other diagnostic images)
- ☐ Rehabilitation Report(s); specify which ones:
  - ☐ **PT** ☐ **OT** ☐ **Speech Therapy**
- ☐ School/Academics/IEP
- ☐ Therapeutic Recreation
- ☐ Discharge Instructions
- ☐ Growth Charts
- ☐ Other: _____

5c. OTHER INFORMATION

* We **won't** release the following information unless the patient or his/her legal guardian **initials** the line next to it. _____ Psychiatric
_____Chemical Dependency _____Social Work _____ Psychology _____ Neuropsychology _____ AIDS/HIV

6. Complete this section if needed: I do not authorize release of the following information: _____
_____

7. I am asking Gillette to release information for this purpose (check the appropriate box):

☐ Continuing Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Education
☐ Other, specify: _____

I understand that:

- I may revoke this authorization at any time by **WRITTEN REQUEST**.
- Revoking my authorization will **NOT** apply to information already released in response to this authorization.
- A photocopy or facsimile of this authorization will be treated in the same manner as if it were the original form.
- Once information is released because of this authorization, Gillette cannot prevent re-disclosure of the information to a third party.
- Gillette may not make treatment, payment, enrollment or eligibility for benefits a condition of my signing this form.
- **This authorization expires one year from the date I sign it.**

8. Initial one of the following statements. (If you don't choose one, we'll only release information gathered up to the date of your signature.)

____I authorize Gillette to release information gathered up until the date I signed this form.
____I authorize Gillette to release information gathered for one year after the date I signed this form, or until date specified here: _____

9. Please sign here.

_____ _____ _____
*Patient/Parent/Legal Responsible party *Relationship *Date

Driver's license or ID required when picking up records. **Proof of Guardianship/Durable POA/court order may be required (see back note)**

(Office Use Only)
A copy of this form must be included with the materials requested

Date Received: _____ Date Processed: _____ Request Completed by: _____

Directions for Completing This Form

NOTE: This form applies only to the patient whose name and date of birth appears in Item 1 on Page 1. If you are not the patient or parent of the patient, you must provide legal guardianship papers, Durable Power of Attorney papers, or court orders (or have them on file at Gillette) before we can process this request.

Be sure to complete all sections of the form that are marked with an asterisk (*). **You must tell Gillette, in writing, if you want to revoke your authorization** (that is, if you want to stop any future release of information that you previously allowed by filling out this form).

1. Write the patient's name and date of birth clearly and legibly. Gillette will add the patient's medical record number.
2. Tell us if you want Gillette to release or receive documents or only exchange information verbally.
3. Give us the name and other requested information for the person or organization to whom you are allowing Gillette to release information to or from.
4. Tell us the beginning and ending dates for which you are allowing us to release information. (For example, you might allow us to release information from 2008 to the present.)
5. Check any and all boxes to show us what information you are allowing us to release.
   5a. If you check "All items in this box," you **<u>are</u>** giving us permission to release **all** of the information in the 5a box: Discharge Summary, Laboratory Reports, Operative Reports, Pathology Reports, History and Physical Exam, Consultation Reports, Outpatient Clinic Notes, Special Testing, and Imaging Reports (but not the actual images). If you only want to allow us to release **some** of the items, do not check the "all items" box; mark the boxes next to information you want us to release.
   5b. If you want us to release **any** of the information in the 5b box, **<u>you must</u>** mark the boxes next to those items. Marking "all items" in the 5a box does not allow us to release information in the 5b box.
   5c. If you want us to release anything in the 5c box (Psychiatric, Chemical Dependency, Social Work, Psychology, Neuropsychology Evaluation or Aids/HIV information), **you must** initial the line next to those items.
6. If there is anything that **you do not want** released, write it down in this section.
7. To help us identify and track your request, mark the box that best describes why you are allowing the information to be released. (Note: In accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524, there might be fees if you request information for personal reasons. We won't charge you to release information to other health care facilities.)
8. Initial the statement that best describes what you want us to do. If you only want us to release past information (information up to and including the date you sign the form), initial the first statement. If you want to allow us to release information for up to one year after you sign the form, initial the second statement. If you want to allow us to release information up until a particular date, initial the second statement and fill in the date after which you want us to stop releasing information.
9. You must sign and date the form.

Direct your questions to:
Gillette Children's Specialty Healthcare—Release of Information
200 University Ave. E.
St. Paul MN 55101
Phone 651-312-3122
Fax 651-229-3888

Authorizations signed for the following:

_____ **Expires:**_____

_____ **Expires:** _____

_____ **Expires:** _____

_____ **Expires:** _____

_____ **Expires:** _____