Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information Fax: 612-813-5980

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:

_____
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How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

Information needed from the following clinics:
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's

☐ Email_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *