PRINT SAVE AS RESET

Authorization for Release of Protected Health Information

Fairview / Health East

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: _____
   Address:_____City:_____State:_____ Zip:_____
   Phone: _____ Fax: _____

2. **Release the records marked below for this condition or date(s) of treatment:** _____
   (if blank, we will release 1 year's worth of most recent records.)
   ☒Pertinent clinic records (office visit, ~~lab/radiology results~~, medications, immunizations)
   ☒Pertinent hospital records (emergency, operative or discharge report, history and physical, ~~lab/radiology results~~)
   ☐X-ray/Radiology films/CDs ☒Immunizations ☒Emergency/Urgent Care ☐EKG/echo reports
   ☐X-ray/Radiology reports ☐ Lab/Pathology reports ☐ *For MD only:* Pathology slides/tissue blocks
   ☒Other (please specify medication list)

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: Crescent Cove Medical Records (attn: care coordinator)
   Phone: 952.426.4711x7 Fax: 612.444.0998
   Address: 4201 58th Ave N City: Brooklyn Center State: MN Zip: 55429

4. **Delivery/format:** Electronic**:** ☐ E-mail and/or MyChart (patient portal) ☐ US mail ☐ CD
   ☒ Fax (only for continuing care) ☐ Will pick up **Date needed by:** _____

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

6. **I understand that:**
   - 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 want substance abuse records released, I should complete the Fairview Recovery Services Authorization to Release Protected Health Information form instead of this form.
   - 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 place 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.
   - My records may include records that you received from other organizations. If you have used these records and filed them in the record you maintain about me, then they may also be included in any release of information.
   - 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.
   - I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
   - 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)***

Directions for Completing the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Please print.

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.

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, or court-appointed Legal Guardianship documents.

Use this form to release records from any HealthEast location, or any of these listed Fairview places: Fairview Facilities.

Contact Information for Release of Information:

University of Minnesota Medical Center & University of Minnesota Masonic Children's Hospital
& University of Minnesota Health Clinics and Surgery Center / Fairview Metro Area Hospitals / Fairview Metro Area Clinics
Release of Information, LL25
6401 France Ave. S.
Edina, MN 55435-2199
Phone: 952-924-5165
Fax: 952-915-8824

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

Grand Itasca Clinic & Hospital
1601 Golf Course Road,
Grand Rapids MN 55744
Phone: 218-326-3401
Fax: 218-999-1513

HealthEast
Release of Information
1690 University Ave.
St. Paul, MN 55104
Phone: 651-232-4999
Fax: 651-232-4887

For other locations, please visit http://www.fairview.orgor www.healtheast.org

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