RELEASE OF INFORMATION – AUTHORIZATION FORM

Hennepin Healthcare

Authorization to Release Health Information

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ Social Sec #: _____ Phone: _____ MR#: _____
Health Information Released FROM:	☑ Hennepin Healthcare System (Hospital and Clinics) ☐ Hennepin County Adult Detention Center ☐ Other: Person/Organization: _____ Street Address: _____ City/State/Zip: _____ FAX: _____ Phone: _____
Health Information Released TO:	Person/Organization: Crescent Cove Medical Records (attn: care coordinator) Street Address: 4201 58th Ave N City/State/Zip: Brooklyn Center, MN 55429 FAX: 651.300.1350 Phone: 952.426.4711x7
Health Information to be Released: **Please note:** Psychotherapy notes will not be released as directed by HIPAA 164.524(a)(1)(I)	Date of Service: _____ Type of Visit: _____ ☒ History and Physical ☐ Photographs ☐ Radiology Reports ☐ Laboratory Reports ☒ Discharge Summary ☐ Radiology Images (not able to fax images) ☒ Emergency Room Report ☒ Progress/Clinic Notes ☐ Dental Report/X-rays ☒ Surgery Report ☒ Care Plan ☒ Visits Report ☒ Medications ☒ Immunizations ☐ Cardiac/EKG Reports ☐ Other (Must specify. **ALL** will not be accepted): _____ **All information regarding alcohol/ drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us NOT to by initialing below:** _____Do Not Release Alcohol/Drug Use or Abuse records _____Do Not Release HIV/AIDS records _____Do Not Release Mental Health records
Form or Format of Release:	☐ Hard Copies (paper) ☒ Electronic (Examples include CD & email) See #5 on instructions for more details regarding electronic releases and risks ☐ Verbal Exchange (no copies) ☐ Review of Record (no copies)
Purpose of Release:	☐ Personal ☐ Attorney ☒ **Continued Care - Appt Date**: _____ ☐ Insurance ☐ Disability/ Social Security ☐ Other: _____ **There may be a charge/fee for copies of records.**
Delivery Method	☐ **Mail** ☒ **Fax** ☐ **Pick up by patient/authorized designee (requires photo ID)** ☒ **Email** Email address: admissions@crescentcove.org
Authorization/ Revocation	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to the HHS's HIM department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that HHS will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X _____ X _____ **Signature** (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) **Date** _____ Relationship to patient (if not patient) **NOTE:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. *A photocopy of this authorization is as valid as the original.*
Staff Use Only	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____

Instructions for Completing Authorization to Release Health Information

To protect our patient's confidential medical information we must have a valid, complete and legible authorization to disclose their health information.

1. **Patient Information: Print the patient's:**
   - Full, legal name - Date of Birth - Include maiden name or any alias names used
   - Phone number - Social security number
2. **Health Information Released FROM:** Check only one of the boxes. If you select Hennepin Healthcare System it will include clinics, emergency room and hospital records; unless otherwise noted in section #4. If choosing "Other" please provide the organization's name and address in which to obtain information.
3. **Health Information Released TO:** Print the name of the person or organization that is to receive the information, be sure to include the complete address, city and state and/or fax number.
4. **Health Information to be Released:** Indicate a date of service, type of visit (clinic, inpatient, radiology, etc.) or specific report types as listed on the form.

   All sensitive information; including alcohol and drug use/abuse records, mental health records and HIV/AIDS records will only be released when the individual items are initialed. Initial each line indicating the specific sensitive information you DO want us to release.
5. **Form or format of release:**
   - **Hard Copies –** check this box if you are allowing paper copies of your information to be given to the party listed in #3. Be sure to indicate what information should be release in the *Health Information to be Released* section. If only allowing release of records relating to specific illness/injury please list it on the *Other* line.
   - **Electronic –** check this box if you are looking to have your information sent to party listed in #3 on via an electronic form such as a CD, USB flash drive or email. Please remember that if you need these records faxed you cannot choose this option. Also note that the recipient of the electronic release will need to have computer applications that allow them to view a PDF file.
     Please note, emailing patient information in an unencrypted email is a risk to your private health information. Email accounts can be compromised or emails in transit can be intercepted. By choosing a release via email, you recognize and accept this risk.
   - **Verbal Exchange –** Check this box if you are allowing verbal discussions of your health and billing information with parties listed**.**
   - **Review of Record–** check this box if you are allowing the review of your medical record by the party listed in #3 above.
6. **Purpose of Release:** Check appropriate box or write in if other purpose. If you have an upcoming appointment that these records are needed for, please provide the appointment date.
7. **Delivery Method:** Please check the box to indicate how the records should be sent to the party in #3.
   - **Mail or Email –** if you check this box please make sure you have a complete address for the party in #3.
   - **Fax –** check this box for continued care release only and be sure to include a fax number for the party in #3.
   - **Pick up by patient/designee –** check this box if you want to have the information picked up. Whomever you would like to pick up the information will need to be listed as the party in #3. The person picking up the information will need to have a valid photo identification card.
   - **There may be a charge for records.**
8. **Authorization/Revocation:** This authorization will terminate one year from the date signed unless you specify an earlier date. Any medical information after the date of signature will not be released. If you need to have your information sent after the date signed on this form please ask the staff for help. The patient or legal representative must sign and date the authorization in order for it to be valid. If a legal representative signs we will need a copy of document showing legal representation.

If help is needed to complete this form, you may contact the HHS HIM Release of Information staff at 612-873-3180 or stop by the department located on Blue 1 at the times listed below:

- **Monday - Friday, 7:00 AM – 5:30 PM**
- **Closed Saturdays, Sundays and Major Holidays**