

University of Minnesota Medical Center, Fairview

Health Information Management Services

Riverside Campus

University Campus

2450 Riverside Avenue
Minneapolis, MN 55454

420 Delaware Street SE
MMC 601
Minneapolis, MN 55455
(612) 626-3238 Tel

(612) 273-4359

Please complete the form below and fax to 612-273-2345.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # 00 ____ - ____ - ____
(please print clearly)

Previous Names _____ Social Security # _____ Birthdate ____ / ____ / ____

Phone Numbers (Home) _____ (Work) _____ (Other) _____

This will authorize Fairview-University Medical Center to request information from _____
(other healthcare facility)

This will authorize Fairview-University Medical Center to release records to:

Name/Organization		
Street Address		
City	State	Zip Code

The following information is to be released (check appropriate boxes):

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> EKG/ECHO Reports |
| <input type="checkbox"/> Counselor's Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Department Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> X-Ray/Radiology Reports | <input type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Hospital Outpatients/Clinic Notes | <input type="checkbox"/> Films | _____ |

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Continued care by another provider | <input type="checkbox"/> Insurance claim purposes | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Attorney review | <input type="checkbox"/> Other _____ | |

- ◆ With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____
Please indicate any restrictions. (Specify) _____
- ◆ I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- ◆ This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
The expiration period noted here may exceed one year only in certain situations as specified by law.
- ◆ I understand there may be a retrieval and copy charge associated with the release.
- ◆ I understand that once information is released pursuant to this authorization, Fairview-University Medical Center can not prevent the re-disclosure of the information to another third party.
- ◆ I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- ◆ Except for research-related treatment, Fairview will not condition treatment on my signing this authorization.

Signature of Patient / Authorized Person
(If authorized person is signing, please also print name)

Authorized Person's authority to sign Date
(parent, guardian, power of attorney, etc.)

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____

Original - Chart /File Copy

Yellow - Patient / Authorized Person Copy

Release of Information Authorization