



Patient Authorization for Release of Protected Health Information



AUTHR

Internal Use Only	MRN _____
	Completed by _____ Date _____
	Release ID _____

Instructions for completing and mailing this form are on page 2.

Patient Information	Patient name		Previous last name (if any)		Phone number		
	Street address		City		State	ZIP code	
Release my records from:	<input type="checkbox"/> HealthPartners			OR	<input type="checkbox"/> External/Outside facility <i>(complete this section only if requesting outside records)</i>		
					Phone number		Fax number
	Specific HealthPartners facility <i>(optional)</i>				Street address		
					City	State	ZIP code
Send my records to:	Person/Business/Hospital/Clinic			Phone number		Fax number	
	Street address			City		State	ZIP code
Information to be released • <i>check only what applies</i> • <i>there may be a charge for records</i> • <i>instructions on back of form</i>	I want health records related to this diagnosis/condition ▶ _____						
	I want health records for these dates of service ▶ _____						
	<input type="checkbox"/> I am requesting a summary of my care. <i>(Summary of care requests include provider notes, imaging reports, medications, labs, immunizations, etc.)</i>		OR choose individual reports	<input type="checkbox"/> I only need the following individual reports/results:			
				<input type="checkbox"/> Billing or Itemized statements	<input type="checkbox"/> Lab or Pathology report		
				<input type="checkbox"/> Consult report	<input type="checkbox"/> Medication list		
				<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Mental health records		
				<input type="checkbox"/> Eye or Optical	<input type="checkbox"/> Operative report		
				<input type="checkbox"/> Emergency department notes	<input type="checkbox"/> Pathology glass slides		
				<input type="checkbox"/> HealthPartners Dental <i>(give request to your dental clinic)</i>	<input type="checkbox"/> Provider note/clinic visit		
				<input type="checkbox"/> History and physical	<input type="checkbox"/> X-ray/Imaging report		
				<input type="checkbox"/> Immunization record	<input type="checkbox"/> Radiology imaging (describe) _____		
				<input type="checkbox"/> Other _____			
Special Permissions	In compliance with federal law, special permission is required to release the following records:						
	<input type="checkbox"/> Programs for Change	<input type="checkbox"/> Alcohol and Drug Abuse Program (ADAP)		<input type="checkbox"/> Hutchinson SUD Program			
	WISCONSIN RECORDS ONLY: Special permission is required to release the following records:						
	<input type="checkbox"/> HIV test results	<input type="checkbox"/> Mental health		<input type="checkbox"/> Developmental disability	<input type="checkbox"/> Substance use disorder		
Purpose for release	<input type="checkbox"/> Continuity of care	<input type="checkbox"/> Personal/My request	<input type="checkbox"/> Disability	<input type="checkbox"/> Review current care			
	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Other _____			
Release method	▼ Date records needed	Onsite records pickup not available; choose one of the following options					
	____ / ____ / ____	<input type="checkbox"/> Release to my online account (patient portal). <i>Not available with all proxy access (see pg2, 7d).</i>	<input type="checkbox"/> Secure email	▶ Indicate email address ONLY if you want your records sent via email.	<input type="checkbox"/> Fax		
				▶ Email may be sent by copy service.	▶ Number _____	<input type="checkbox"/> Mail	
Authorization and Revocation	<ul style="list-style-type: none"> I authorize HealthPartners to release the information marked above. HealthPartners will not withhold treatment or insurance payment based on whether I sign this form. Records released may include information received from other organizations. Records released may no longer be protected by law and could be redisclosed by the recipient. Federal regulations prohibit the recipient of substance use disorder records from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted (42.CFR.2.32). There may be a charge for records. This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified. ▶ _____ I may revoke this authorization by sending a written request to the appropriate HealthPartners Release of Information department <i>(see section 8 on back of form)</i>. 						
	Patient signature		Date		If other than patient, state relationship and authority to sign		

Instructions to complete the Patient Authorization for Release of Protected Health Information

- 1. Patient Information:** Complete the entire section. Print legibly and include all demographic information.
- 2. Who has the information you want released?**
 - When requesting records to be sent from a HealthPartners facility, there is an option to name just a specific facility within the HealthPartners organization. For a description of HealthPartners, please see Notice of Privacy Practices.
 - **External/Outside Facility section:** If records are needed from another healthcare organization, fill this section out with as much demographic information as possible. You will send this authorization to the facility listed in this section.
- 3. Where do you want the information sent?**
 - Print where you want your health information sent (e.g., individual, business, other healthcare facility).
 - Include as much demographic information as possible.
 - No authorization is required to send records from one HealthPartners facility to another HealthPartners facility.
- 4. Information to be sent:** In this section you will tell us what information you need. We have identified 3 categories: summary of care, individual documents and special permissions. You do not need to complete all 3 categories; use only those that apply to your specific need.

Paper charts stored offsite are not included in the Standard Record Set for entire/any and all requests, but they may be released when specifically requested.
- 5. Special Permissions:** If applicable, in this section you must specifically identify records needed by checking the appropriate box.
- 6. Purpose for Release:** Indicate reason for releasing the health information. Checking this box will assist us in tracking, assigning priority and who may be responsible for the cost of records (as appropriate).
 - **Review current care:** Patients requesting records to review current care are entitled to those records at no charge. HealthPartners defines current care as the most recent 6 visits. If requests are received to review current care but the patient is requesting more records than current care permits, there may be fees associated with the release of those records.
- 7. Release method:** This tells us how you would like your information delivered.
 - a. Entering a date ensures that your records will be available when you need them.
 - b. Multiple electronic delivery options are available (e.g., email, online patient portal).
 - c. If an email option is chosen, you may receive an email from the organization's copy service vendor. It will include your user information to access the requested records.
 - d. Online patient portal delivery is not available in all proxy access situations. If you are a proxy for a 13-17 year old or a proxy for an adult patient, request mail, fax or secure email delivery.
 - e. If records are requested via regular mail, be advised that requests more than 75 pages will be delivered via regular mail on an encrypted CD. Electronic delivery is encouraged for larger-volume releases.
- 8. Authorization and Revocation**
 - Sign and date authorization. A photocopy or fax of this authorization will be treated the same as an original.
 - When requesting email delivery, be sure your email address is written VERY clearly.
 - If you are legally authorized representative, indicate your relationship to the patient on form in space provided. You may be asked to provide documents showing that you are the patient's legally authorized representative.
 - Authorization is valid for one year unless otherwise specified.
 - Services provided after the date of signature may be released according to the authorization up until authorization expires.
 - **There may be a charge for records.**
 - To revoke the authorization, submit a written request and mail to appropriate address below. The revocation will take effect upon receipt.
 - For questions, please call the HealthPartners Release of Information department below.
- 9. HealthPartners Release of Information contact information**

HealthPartners Release of Information

Mailstop: 61N011
3800 Park Nicollet Blvd.
St. Louis Park, MN 55416
Tel 952-993-7600 Fax 952-883-9714 or 952-883-9768

Billing Records

Amery Hospital & Clinics
Tel 715-268-8000 Fax 715-268-0261
HealthPartners Clinic
Tel 651-265-1999 Fax 952-883-9628
Hudson Hospital
Tel 715-531-6200 Fax 715-531-6201
Hutchinson Health
Tel 320-484-4493 Fax 952-883-3094
Lakeview Hospital
Tel 651-430-4533 Fax 651-430-8536
Olivia Hospital & Clinic
Tel 320-523-8300 Fax 320-523-8349
Park Nicollet/Methodist Hospital/TRIA
Tel 952-993-7672 Fax 952-993-7532
Regions Hospital
Tel 651-254-4791 Fax 651-254-0954
Stillwater Medical Group
Tel 651-439-1234 Fax 651-351-0827
Westfields Hospital & Clinics
Tel 715-243-2600 Fax 715-243-2786

Radiology

Amery Hospital & Clinics
Tel 715-268-0476 Fax 715-268-0481
Hudson Hospital & Clinics (*Imaging CDs*)
Tel 715-531-6230 Fax 952-883-9663
Hudson Hospital & Clinics (*Images pushed*)
Tel 715-531-6435 Fax 952-883-9727
Hutchinson Hospital & Clinics
Tel 320-484-4660 Fax 952-993-1718
Lakeview Hospital & Clinic
Tel 651-430-4615 Fax 651-430-4560
Olivia Hospital & Clinics
Tel 320-523-3464 Fax 320-523-3494
Park Nicollet/Methodist Hospital
Tel 952-993-5402 Fax 952-993-1718
Regions/HealthPartners
Tel 651-254-3794 Fax 651-254-5705
Westfields Hospital & Clinics
Tel 715-243-2730 Fax 715-243-2732

Capitol View Transitional Care Center

Tel 651-254-0453 Fax 833-994-0845

Community Services

Afton Place
Tel 651-254-0500 Fax 651-731-5847
Hovander House
Tel 651-254-4370 Fax 651-251-2190

HP Dental

Tel 952-883-5155 Fax 952-883-5160