Patient Authorization for Release of Protected Health Information

AUTHR

1. Review and complete all sections of the form.
2. Click the PRINT button at the bottom of the page, then sign, date and submit to your clinic.
3. To print the blank form, do not fill out the boxes and click the PRINT button at the bottom of the page.
4. Call 952-993-7600 with questions.

Help

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	Date of birth

Release my records from:

☐ **HealthPartners**

Specific HealthPartners facility ***(optional)***

OR

☐ **External/Outside facility** *(complete this section only if requesting outside records)*

Phone number	Fax number

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

- *check only what applies*
- *there may be a charge for records*
- *instructions on back of form*

I want health records related to this diagnosis/condition ▸ _____

I want health records for these dates of service ▸ _____

☐ **I am requesting a summary of my care.** (Summary of care requests include provider notes, imaging reports, medications, labs, immunizations, etc.)

OR choose individual reports

☐ **I only need the following individual reports/results:**

- ☐ Billing or Itemized statements
- ☐ Consult report
- ☐ Discharge summary
- ☐ Eye or Optical
- ☐ Emergency department notes
- ☐ HealthPartners Dental *(give request to your dental clinic)*
- ☐ History and physical
- ☐ Immunization record
- ☐ Lab or Pathology report
- ☐ Medication list
- ☐ Mental health records
- ☐ Operative report
- ☐ Pathology glass slides
- ☐ Provider note/clinic visit
- ☐ X-ray/Imaging report
- ☐ Radiology imaging (describe)_____
- ☐ Other _____

Special Permissions

In compliance with federal law, special permission is required to release the following records:

☐ Programs for Change ☐ Alcohol and Drug Abuse Program *(ADAP)* ☐ Hutchinson SUD Program

WISCONSIN RECORDS ONLY: Special permission is required to release the following records:

☐ HIV test results ☐ Mental health ☐ Developmental disability ☐ Substance use disorder

Purpose for release

☐ Continuity of care ☐ Personal/My request ☐ Disability ☐ Review current care

☐ Transfer of care ☐ Insurance ☐ Legal ☐ Other _____

Release method

▾ Date records needed

____ /____ /____

Onsite records pickup not available; choose one of the following options

☐ Release to my online account (patient portal). *Not available with all proxy access (see pg2, 7d).*

☐ Secure email ▸ *Indicate email address **ONLY** if you want your records sent via email.* ***Email may be sent by copy service.***

▸ Email address _____

☐ Fax ▸ Number _____

☐ Mail

Authorization and Revocation

- 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 *(see section 8 on back of form)*.

Please review the information you have entered above. If you are satisfied with your entries, click the PRINT button at right, sign and submit the form to your clinic. If you need to make changes, click the CLEAR button at right and begin again. If you'd like to print a blank copy of the form, don't fill out the boxes and click PRINT at right.

Print Clear

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 of Current Care:** HealthPartners releases a standard record set for patient review of current care at no charge to the patient.
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: 61N01I
3800 Park Nicollet Blvd.
St. Louis Park, MN 55416
Tel 952-993-7600 Fax 952-883-9714 or 952-883-9768

Billing Customer Service

Amery Hospital & Clinics
Tel 715-268-8000 Fax 952-993-7532

HealthPartners Clinic
Tel 651-265-1999 Fax 952-993-7532

Hudson Hospital
Tel 715-531-6200 Fax 952-993-7532

Hutchinson Health
Tel 320-484-4493 Fax 952-993-7532

Lakeview Hospital
Tel 651-430-4533 Fax 952-993-7532

Olivia Hospital & Clinic
Tel 320-523-8300 Fax 952-993-7532

Park Nicollet Clinics & Methodist Hospital
Tel 952-993-7672 Fax 952-993-7532

Regions Hospital
Tel 651-254-4791 Fax 952-993-7532

Stillwater Medical Group
Tel 651-439-6528 Fax 952-993-7532

TRIA Orthopedic Centers
Tel 952-993-5463 Fax 952-993-7532

Westfields Hospital & Clinics
Tel 715-243-2785 Fax 952-993-7532

Radiology

Amery Hospital & Clinics
Tel 715-268-0476 Fax 715-268-0481

Hudson Hospital & Clinics
Tel 715-531-6435 Fax 715-531-6439

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