



Release of Information Services
MS 25510C
PO Box 1490
Minneapolis, MN 55440-1490

Online Patient Services System
Adult Proxy Access Request

Patients Full Name: Daytime phone number:
Address: City: State: Zip:
Gender: M or F Date of Birth: Medical Record Number:

I authorize the disclosure and use of health information as described below:

1. I authorize HealthPartners Medical Group to disclose (give out) this information via the Online Patient Services system.

2. Who may receive and use this information: (Please print - If additional space is needed, please use the back of the form)

Full Name: Daytime phone number:
Address: City: State: Zip:
Gender: M or F Date of Birth: Medical Record Number:

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3. This information will be disclosed for viewing of the medical record in Online Patient Services.

4. All portions of my medical record that are accessible through HealthPartners Online Patient Services system will be accessible. Online Patient Services includes selected, limited information from my medical record and does not include progress notes, eye/optical records, dental record, x-ray and other images, and consultation reports.

5. This authorization expires (ends) 12 months from the date I sign this form unless I specify an earlier date:

I understand that:

- This authorization relates only to HealthPartners Online Patient Services system.
I may revoke this authorization at any time by notifying, in writing, the facility listed above.
Revoking this authorization does not apply to information that has already been released under this authorization.
If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws.
Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

Signature of Patient

Date

Mail completed and signed form to: Release of Information Services, MS 25510C, PO Box 1490, Mpls, MN 55440