HealthPartners®

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)
Street address			Date of birth
City	State	ZIP code	Phone number

Who has the information you want released?

Hospital/Clinic/Healthcare Clinician	Phone number	Fax number	
Street address	City	State	ZIP code

Where do you want the information sent?

Person/Business/Hospital/Clinic	Phone number	Fax number	
Street address	City	State	ZIP code

Information you want sent *(check only what applies) (see instructions on back of form)*

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

I want health records for these dates of service ▸ _____

☐ Clinic visit (includes provider note, lab results, imaging report, med list, immunizations)

☐ Hospital care (includes emergency department note, history and physical, operative report, lab results, imaging report, discharge summary)

I only want *individual* reports/results related to this diagnosis/condition ▸ _____

I only want *individual* reports/results checked below for these dates of service ▸ _____

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

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	☐ Other
☐ Transfer of care	☐ Insurance	☐ Legal	_____

Release method *(choose one)*

Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information.

▸ Date records needed (appointment date) ____ /____ /____

Paper ▸ ☐ Mail

☐ Fax ▸ Number _____

☐ Release to myChart (patient portal)

Electronic ▸ ☐ Secure email ▸ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service.** Radiology images cannot be sent via email.*

▸ Email address _____

Authorization and Revocation

- I authorize the HealthPartners Family of Care to release the information marked above. HealthPartners Family of Care will not withhold treatment or insurance payment based on whether I sign this form. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed.
- 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.
- **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). The revocation will take effect upon receipt.
- A photocopy/fax of this authorization will be treated in the same way as an original.

Patient signature	Date
If other than patient, state relationship and authority to sign	

Any changes to this form must be reviewed and approved by Health Information Management.

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?**
   - If requesting records to be sent from a HealthPartners facility, see address list on bottom of page.
   - If other healthcare organization, include as much demographic information as possible.
   - You will send this authorization to the facility listed in this section.
   - For a description of HealthPartners Family of Care, please see Notice of Privacy Practices.
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.
   - You do not need to use an authorization 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: clinic visit/hospital 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 (dates range, depending on facility) are not included in the Standard Record Set for entire/any and all requests, but they may be specifically requested and released if needed.
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).
7. **Release method:** This tells us how you would like your information delivered.
   - If you have upcoming appointment *enter appointment date*. Entering a date ensures that your records will be available at your appointment.
   - 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.
8. **Authorization and Revocation**
   - Sign and date authorization.
     - When picking up records in person, bring photo identification. You *will* be asked for this.
     - 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 other 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 location (see address list below).
   - For questions, please call the HealthPartners Family of Care Release of Information department below.
9. **HealthPartners Family of Care Release of Information addresses/telephone/fax information**

Amery Hospital and Clinic
Release of Information *(office located at Westfields)*
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3501
Fax 952-883-9731

HealthPartners Medical Clinics
Release of Information
MS: 11501K
P.O. Box 1490, Minneapolis, MN 55440-1490
Tel 952-993-7600
Fax 952-883-9714

Hudson Hospital and Clinic
Release of Information
405 Stageline Road, Hudson, WI 54016
Tel 715-531-6230
Fax 952-883-9663

Hutchinson Health Hospital & Clinics
Release of Information
1095 Hwy. 15 South, Hutchinson, MN 55350
Tel 320-484-4525
Fax 952-883-3084

Lakeview Hospital/Stillwater Medical Group
Release of Information
927 Churchill Street W., Stillwater, MN 55082
Tel 651-430-4596
Fax 952-883-9798

Park Nicollet/Methodist Hospital/ TRIA Orthopaedics
Release of Information
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9768

Regions Hospital and Clinics
Mail Stop 11501E - Release of Information
640 Jackson Street, St. Paul, MN 55101
Tel 651-254-2468
Fax 952-883-9614

Westfields Hospital and Clinic
Release of Information
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3406
Fax 952-883-9729

For facilities below, follow their instructions:

Capitol View Transitional Care Center	Tel 651-254-0453	Fax 651-254-0422
Community Services		
Afton Place	Tel 651-254-0500	Fax 651-731-5847
Hovander House	Tel 651-254-4370	Fax 651-251-2190
Safe House	Tel 651-254-4744	Fax 651-726-2470
HP Dental	Tel 952-883-5155	Fax 952-883-5160
Home Healthcare & Hospice	Tel 952-883-6875	Fax 952-883-9779
Physicians Neck and Back	Tel 651-631-4242	Fax 952-883-9768
Billing Records		
HealthPartners Clinic	Tel 651-265-1999	Fax 952-883-9628
Regions Hospital	Tel 651-254-4791	Fax 651-254-0954
Park Nicollet/Methodist Hospital/TRIA	Tel 952-993-7672	Fax 952-993-7532
Radiology (images on CD)		
Regions/HealthPartners	Tel 651-254-3794	Fax 651-254-5705
Park Nicollet/Methodist Hospital	Tel 952-993-5402	Fax 952-993-1718
Westfields Hospital	Tel 715-243-2730	Fax N/A