

ALLINA HOSPITALS & CLINICS AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____																				
Clinic/Hospital/Health Care Provider – (Who has the information you want released?) Please list the specific Hospital and/or clinic.	NAME: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____																				
Receiving Party (Where do you want the information sent? Who may have the information?)	NAME: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____ Fax Number (URGENT PATIENT CARE ONLY) _____																				
Information to be Released (What do you want sent or released? Check the appropriate box.)	Routine Record Sets (indicate date(s) of service _____) <input type="checkbox"/> Clinic (office visit, lab, radiology, medicines, immunizations) <input type="checkbox"/> Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) <input type="checkbox"/> Billing Records <input type="checkbox"/> Copies of Films/Images <input type="checkbox"/> Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.) Only records types checked below: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Discharge summary/note</td> <td><input type="checkbox"/> Radiology reports</td> <td><input type="checkbox"/> Emergency record(s)</td> <td><input type="checkbox"/> Medication records</td> </tr> <tr> <td><input type="checkbox"/> History & physical exam</td> <td><input type="checkbox"/> Rehab records (PT/OT/ST)</td> <td><input type="checkbox"/> Immunization/allergy record</td> <td><input type="checkbox"/> Chemical dependency/</td> </tr> <tr> <td><input type="checkbox"/> Operative report</td> <td><input type="checkbox"/> Laboratory reports</td> <td><input type="checkbox"/> Pathology reports</td> <td>Substance abuse records</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Progress notes/clinic notes</td> <td><input type="checkbox"/> Mental health records</td> <td><input type="checkbox"/> Pathology slides/blocks</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Other records specify record type(s) _____</td> </tr> </table> OPTIONAL Limits - Disclose only records related to following: Date(s) of service: _____ injury or illness: _____	<input type="checkbox"/> Discharge summary/note	<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Emergency record(s)	<input type="checkbox"/> Medication records	<input type="checkbox"/> History & physical exam	<input type="checkbox"/> Rehab records (PT/OT/ST)	<input type="checkbox"/> Immunization/allergy record	<input type="checkbox"/> Chemical dependency/	<input type="checkbox"/> Operative report	<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Pathology reports	Substance abuse records	<input type="checkbox"/> Consultations	<input type="checkbox"/> Progress notes/clinic notes	<input type="checkbox"/> Mental health records	<input type="checkbox"/> Pathology slides/blocks	<input type="checkbox"/> Other records specify record type(s) _____			
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Release Instructions (How and When do you want the information?)	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) Release Method / Format requested: (check one) <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> View my Record <input type="checkbox"/> Fax (patient care only) <input type="checkbox"/> Verbal Continuing Care Information released by Nursing Station/Department (verbal and paper) <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Purpose of Release (Why is it needed?)	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Continuing care</td> <td><input type="checkbox"/> Transfer of care</td> <td><input type="checkbox"/> Social security appeal</td> </tr> <tr> <td><input type="checkbox"/> Insurance application *</td> <td><input type="checkbox"/> Personal use or review *</td> <td><input type="checkbox"/> Social security disability determination *</td> </tr> <tr> <td><input type="checkbox"/> Insurance payment/claim</td> <td><input type="checkbox"/> Litigation/legal *</td> <td></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other* _____</td> </tr> </table> * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524	<input type="checkbox"/> Continuing care	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Social security appeal	<input type="checkbox"/> Insurance application *	<input type="checkbox"/> Personal use or review *	<input type="checkbox"/> Social security disability determination *	<input type="checkbox"/> Insurance payment/claim	<input type="checkbox"/> Litigation/legal *		<input type="checkbox"/> Other* _____										
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• This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____ • This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Allina Notice of Privacy Practice describes how to cancel (revoke) this authorization. • Allina Hospitals & Clinics will not restrict my treatment if I choose not to sign this authorization. • A photocopy/fax of this authorization will be treated in the same way as an original. • Allina's records may include records that it received from other organizations. If these records have been used by Allina and filed in the record Allina maintains about you, these records may be released with your Allina records. • Allina cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Allina from any and all liability resulting from a redisclosure by the recipient. • Your signature indicates that you have read and understand this form, and authorize release of your information as described above.																					

Patient/Legal Guardian Signature

Date

Authority to act on behalf of patient (attach document)

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for)

Clinic/Health care Provider: Identify which Allina hospital or clinic you are seeking information from (or to be sent to). **Please be specific** in your request. For example, United Hospital, St. Paul, MN; Buffalo Hospital, Buffalo, MN; AMC Shoreview, Shoreview, MN; Aspen Bandana Square, St. Paul, MN; Quello Lakeville Clinic. If you do not identify a specific hospital or clinic (e.g. Allina Hospitals & Clinics), records may be provided from **ALL** Allina hospitals or clinics where you have received care. Please see Allina.com/medical records for a listing of Allina hospital and clinic locations and addresses.

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is to *receive* the information. Please note: It is Allina's policy **NOT** to fax or email patient information except for direct patient care requirements (e.g. to a doctor or clinic). *Please allow 7-10 days for all requests to be processed and sent to the recipient.*

Information to Be Released: This section gives us the instructions for what information you want released. If you select "Routine Record Set" for hospital or clinic, we will disclose the documents that are specific to that patient care visit. This is typically what doctors' offices, hospitals or other health care providers need to provide information related to your care. If you select "any and all" records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor.

Release Instructions: This tells us how you would like your information delivered. We can print the documents or create a CD. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. Please note that viewing appointments are done at the Allina Corporate Office in Minneapolis. If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section (example: form on file for access by my husband upon his specific request).

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date. You may indicate the consent is valid "5 years", "10 years", "forever including after my death". The authorization is revoked at your written direction to our organization.

Contact Information

Health Information/ROI – Mail Route 10203
Allina Hospitals & Clinics
PO Box 43
Minneapolis, MN 55440-0043

Phone: 612-262-2300
Fax: 612-262-2323

For a list of Allina Hospitals & Clinics locations and addresses, please visit Allina.com