ALLINA HEALTH
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: c/o Compex Legal Servic

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 _____)

- ☒ Clinic (office visit, lab, radiology, medicines, immunizations)
- ☒ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)

☒ Billing Records
☒ Copies of Films/Images
☐ Community Pharmacy Charges
☒ 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:

☐ Discharge summary/note	☐ Radiology reports	☐ Emergency record(s)	☐ Medication records
☐ History & physical exam	☐ Rehab records (PT/OT/ST)	☐ Immunization/allergy record	☐ Chemical dependency/ Substance abuse records
☐ Operative report	☐ Laboratory reports	☐ Pathology reports	
☐ Consultations	☐ Progress notes/clinic notes	☐ Mental health records	☐ Pathology slides/blocks

☐ Other records specify record type(s) _____

OPTIONAL Limits - Disclose only records related to following:
Date(s) of service/: injury or illness:

Release Instructions

(***How*** and ***When*** do you want the information?)

Date information is needed: ASAP (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)

Release Method / Format requested: (check one)

☒ *Paper* ☒ *CD/DVD* ☐ *View my Record* ☐ *Fax* (patient care only) ☐ *Verbal*

Continuing Care Information released by Nursing Station/Department (verbal and paper) ☐ Yes ☐ No

Purpose of Release

(***Why*** is it needed?)

☐ Continuing care	☐ Transfer of care	☐ Social security appeal
☐ Insurance application *	☐ Personal use or review *	☐ Social security disability determination *
☒ Insurance payment/claim	☐ Litigation/legal *	
☒ Other* Evaluation of a claim		

*** Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524**

- 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 Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Allina Health 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 Health records may include records that it received from other organizations. If these records have been used by Allina Health and filed in the record Allina Health maintains about you, these records may be released with your Allina Health records.
- Allina Health 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 Health 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 Health 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; Allina Medical Clinic Shoreview, Shoreview, MN; Aspen Medical Group - Bandana Square, St. Paul, MN; Quello Clinic Lakeville. If you do not identify a specific hospital or clinic (e.g. Allina Health), records may be provided from ***ALL*** Allina Health hospitals or clinics where you have received care. Please see allinahealth.org/medical records for a listing of Allina Health 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 Health 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 Health 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 or event. You may indicate the consent is valid "5 years", "10 years", but there needs to be an ending date. The authorization is revoked at your written direction to our organization.

Contact Information for Patient Record Copies

Health Information/ROI – Mail Route 10203
Allina Health
PO Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-2300
Fax: 612-262-2323

Contact Information for Allina Health Pharmacy Charges Copies

Allina Health Pharmacy – Mail Route 10807
Allina Health
PO Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-5980
Fax: 612-262-5988

For a list of Allina Health locations and addresses, please visit allinahealth.org