ALLINA HOSPITALS AND 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 Hospitals 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 # (URGENT PATIENT CARE ONLY)** ______________________
Information to be Released (***WHAT*** do you want sent or released? Check appropriate box))	Routine Record Sets **(indicate date(s) of service** ______________) ☐ Clinic (office visit, lab, radiology, medications, immunizations) ☐ Hospital (History and Physical, Discharge Summary, Operative Report, Consultations, Emergency, Laboratory, Radiology) ☐ Billing Records ☐ Copies of Films/Images ☐ 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:** ______________ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)** **Release Method / Format requested: (circle 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*** ______________________ *** 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 cancelled 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 and 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/Healthcare 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 and Clinics), records may be provided from ***ALL*** Allina Hospitals or Clinics where you have received care. Please see www.Allina.com/medical records for a listing of Allina Hospitals 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 doctor's offices, hospitals or other healthcare 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 and Clinics
PO Box 43
Minneapolis, MN 55440-0043

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

For a listing of Allina Hospitals & Clinics locations and addresses, please see our webpage at www.Allina.com