Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

MRN: _____(*office use only*)

Children's – Minneapolis
Health Information Management (HIM)
2525 Chicago Avenue South
Mail stop 32-B701
Minneapolis, MN 55404
Phone: 612-813-6216
Release of Information Fax: 612-813-6137

Children's – St. Paul
Health Information Management (HIM)
345 North Smith Avenue
Mail stop 70-102
St. Paul, MN 55102
Phone: 651-220-6150
Release of Information Fax: 651-220-5079

Attention: If faxing medical records to Children's please fax to: 612-813-6137
Or to this number:
_____

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

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

Information needed by (date): _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

☐Discharge Summary	☐Operative Report	☐Consultation	☐Immunizations
☐Emergency Department Visit	☐Laboratory Report	☐Education Record	☐Testing Records
☐History and Physical	☐X-Ray Report	☐Clinic Visit	☐Rehab Report
☐Progress Notes	☐X-Ray Image(s)	☐Mental Health Record	☐Nutrition Report
☐Orders	☐Other: _____		
☐**All Health Information**			

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal

☐ E-mail_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *