

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

MRN: _____ (office use only)

**Children's Minnesota
Health Information
Management (HIM)
2525 Chicago Ave S,
B832
Minneapolis, MN 55404**

**Release of Information
Phone: 952-992-5200
Fax: 612-813-5980**

(Office 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: _____

Information needed from the following clinics:

☐ Children's Heart Clinic ☐ Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐ Partners in Pediatrics (PIP) Clinic ☐ Children's West St. Paul Clinic

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

☐ School nurse Electronic Medical Record access (Includes All Health Information)

☐ All Health Information (Does not include imaging or billing information)

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

☐ Email _____ (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: _____



RELINFO