<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**I authorize (release from):**

<table>
<thead>
<tr>
<th>Hospital/Clinic/School/Other</th>
<th>Phone/Fax</th>
</tr>
</thead>
</table>

**To release to:**

<table>
<thead>
<tr>
<th>Name/Hospital/Clinic/School/Other</th>
<th>Phone/Fax</th>
</tr>
</thead>
</table>

**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
- [ ] History and Physical
- [ ] X-Ray Report
- [ ] Testing Records
- [ ] Mental Health Record
- [ ] Progress Notes
- [ ] X-Ray Image(s)
- [ ] All Health Information (Does not include imaging or billing information)
- [ ] Billing Information
- [ ] Other: ____________________________
- [ ] School nurse Electronic Medical Record access (Includes All Health Information)

**Release Method requested:**
- [ ] Paper
- [ ] Fax (patient care only)
- [ ] Verbal
- [ ] MyChildren’s
- [ ] Email (HIM only)

**I understand**
- [ ] 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: ____________________________

<table>
<thead>
<tr>
<th>Signature of the Parent/Guardian/Patient</th>
<th>Date Signed</th>
</tr>
</thead>
</table>

**Relationship to Patient:**
- [ ] Mother
- [ ] Father
- [ ] Patient
- [ ] Other: ____________________________