

**Children's Minnesota
Health Information
Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information
Fax: 612-813-5980**

(Office use only)
Staff Initials _____

of pages _____

ID Verified: Yes
Comments: _____

How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management**.

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

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 MyChildren's
 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: _____

