

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: 612-813-5980

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: 612-813-5980

Attention: If faxing medical records to Children's please fax to: 612-813-5849
Or to this number: _____

(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: _____

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Consultation | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Emergency Department Visit | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Education Record | <input type="checkbox"/> Testing Records |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> X-Ray Report | <input type="checkbox"/> Clinic Visit | <input type="checkbox"/> Rehab Report |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray Image(s) | <input type="checkbox"/> Mental Health Record | <input type="checkbox"/> Nutrition Report |
| <input type="checkbox"/> Orders | <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> 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: _____

