Hutchinson Health
HealthPartners®

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION FORM 1754

PATIENT INFORMATION	**NAME:** _____ **DATE OF BIRTH:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State** _____ **Zip:** _____
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?**) Please list the specific Hospital and/or clinic.**	**NAME:** _____ **Fax Number:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State** _____ **Zip:** _____
Information Exchange	☐ **Information Exchange**
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	**NAME:** _____ **Attention to:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State** _____ **Zip:** _____ **Fax Number (URGENT PATIENT CARE ONLY)** _____
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	Date(s) of service from: _____ to: _____ Related to a specific injury or illness: _____ ☐ Clinic (office visit, lab, radiology, medicines, immunizations) ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) ☐ Billing Records ☐ Copies of Films/Images ☐ All records including ALL types of record listed below (minimum necessary will be released) ☐ excluding behavioral/mental health and substance abuse ☐ including behavioral/mental health and substance abuse ☐ N/A behavioral/mental health and substance abuse If you want to include images and billing records, check those boxes Only record types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Mental health records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Chemical dependency ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Substance abuse records ☐ Consultations ☐ Progress notes/clinic notes ☐ Medication records ☐ Psychiatric Evaluation ☐ Other records specify record type(s) _____
Release Instructions (***How*** and ***When*** do you want the information?)	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) Release Method / Format requested: (check one) ☐ *Paper* ☐ *CD* ☐ *Fax* ☐ *Verbal* ☐ *MyChart*
Purpose of Release (***Why*** is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social security appeal * ☐ Insurance application * ☐ Personal use or review * ☐ Social security disability ☐ Insurance payment/claim ☐ Litigation/legal * determination * ☐ Other* _____ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Hutchinson Health will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Hutchinson Health cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Hutchinson Health from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Forward Release of Information form to HIS for (check one) ☐ HIS to complete request ☐ HIS to file in patient chart

_____ _____ _____

Patient/Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Clinic/Health Care Provider: Identify hospital or clinic you are seeking information from (or to be sent to). *Please be specific* in your request. For example, Hutchinson Health Orthopedic & Rehab Clinic; Hutchinson Health Clinic; Hutchinson Health Hospital.

Receiving Party: Identify the full name, address, phone number and contact information of the individual/business who is *to receive* the information. *Please allow 7-10 days for all requests to be processed and sent to the recipient*.

Information to Be Released: This section gives us the instructions for what information you want released.

Release Instructions: This tells us how you would like your information delivered. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date. You may indicate the consent is valid “5 years”, “10 years”, “forever including after my death”. The authorization is revoked at your written direction to our organization.

Contact Information

Health Information/ROI
Hutchinson Health
1095 Hwy 15 South
Hutchinson, MN 55350

Phone: 320- 234-5000
Fax: 320-484-4684

For a list of Hutchinson Health Hospital & Clinics locations and addresses, please visit Hutchhealth.com