HealthPartners

Medical & Dental Clinics
Central Minnesota Clinics
2251 Connecticut Ave South
Sartell, MN 56377

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information

Name: _____ Previous _____

Date of Birth: _____ Daytime Telephone # _____

Address: _____

City: _____ State: _____ Zip: _____

Health Information Released FROM

☒ HealthPartners Clinics Dr.

☐ Other Provider/Person/Organization _____

Address: _____

City: _____ State: _____ Zip: _____

Health Information Released TO

Person/Organization: (If copies are requested include **COMPLETE** address)

Hoosier Services, Inc.
18032 Lemon Drive Suite C-618
Yorba Linda, CA 92886 Email:service@hoosierservicesinc.com

Purpose of Disclosure

☐ Continuity of care ☐ Transfer of care ☐ Consultation ☐ Disability ☒ Insurance ☐ Legal/Attorney
☐ Payment ☐ Personal ☐ Other (Please explain) _____

Health Information to be Released

☒ **Copies of Records**

☒ Entire Medical Record (Includes all records listed)
☐ Office Notes
☐ History and physical report
☐ Clinic Procedure/operative report
☐ Consultation report,(doctor, date) _____
☐ Behavioral (Mental) Health
☐ Dental Records (Please give request to your Dental Clinic for this release)
☒ Other (as described here)
All Medical Records from _____

☐ **Verbal Exchange (no copies)**

☐ Laboratory results
☐ X-ray/Imaging results
☐ Appointment Information
☐ Chemical Health records

☐ Immunization record
☐ Allergy list
☐ Medication Information
☐ Eye/Optical records
☐ Radiology image film/CD

*Unless specifically excluded, behavioral/mental health information, HIV information, and/or alcohol/drug abuse information appearing in the information selected above will be disclosed. **Do not release records/information related to:*** ☐ *Behavioral/Mental Health* ☐ *HIV/HIV related illnesses* ☐ *Alcohol and/or drug abuse*

There may be a charge for copies of your records per Minnesota Statute 144.292

Method of Delivery

☐ Mail to Recipient ☐ Pick up on ___/___/___ Picture ID is required when picking up records.
☒ Fax to: 18008824957 ATTN: Customer Service ☐ Other:

Authorization

This authorization expires (ends) on the following date, event,or condition: _____
This authorization will expire no more than twelve (12) months from the date I sign this form unless specifically permitted by law.

I understand that:

☐ I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in the FROM section.
☐ Revoking this authorization does not apply to information that has already been released under this authorization.
☐ I have the right to inspect or obtain a copy of the health information disclosed.
☐ If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities, may not be protected by state or federal laws and may be re–disclosed.
☐ I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance company.

_____ _____
Signature of Patient or Patient's Representative *Signature Date*

_____
Print name of Representative

_____
Signature of Witness

900205