AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION/ PATIENT REQUEST FOR ACCESS TO PATIENT HEALTH INFORMATION

Patient Name (Last, first, middle initial) _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Day Phone # _____ Evening Phone # _____

INFORMATION RELEASED FROM	INFORMATION RELEASED TO/EXCHANGED WITH
(Name of Staff Member or Department)	Name (Hospital, clinic, attorney, insurance company, individual)
(Facility Name and Address)	Street Address
	City State Zip
	Date Information Needed

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

Medical Condition/Specify Injury _____

Approximate Visit Dates _____ ☐ View Record ☐ Receive Copy

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

☐ Discharge Summary ☐ Operative Report ☐ Laboratory Report(s) ☐ Emergency Record(s)
☐ Radiology Report ☐ Consultation(s) ☐ Chemical Dependency/Drug or Alcohol Abuse Treatment Records
☐ Radiology Films ☐ History and Physical ☐ Pathology Report ☐ Billing Records/Statements (date) _____
☐ Secondary Records (specify film/video/monitor tracings) _____ ☐ Other _____

-OR-

☐ **Any and all medical records (including billing records and secondary records, chemical dependency/drug or alcohol abuse treatment records**

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH AND/OR HIV/HIV RELEATED ILLNESSES WILL BE RELEASED UNLESS INDICATED HERE:

☐ **DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV**

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

☐ Patient Access ☐ Insurance Application ☐ Social Security Disability Determination ☐ Social Security Disability Appeal
☐ Litigation ☐ Continuing Care ☐ Insurance Payment

Other (specify) _____

Authorization expiration date or event: _____ **(if left blank, will expire one year from date of signature)**

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. Allina will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy/fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Allina cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore Allina is released from any and all liability resulting from redisclosure. I have read and understand my rights as described on the back side of this form.

Patient/Legal Representative Signature _____ Date _____ Authority to act on behalf of Patient (attach document) _____

Information released by Nursing Station/Other/Verbally ☐ No ☐ Yes By _____ Date _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

PLACE BAR CODE HERE

A10002 (3/03)

ALLINA HOSPITALS & CLINICS

PLEASE READ THE FOLLOWING INFORMATION
PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

You have the right to inspect and obtain a copy of your protected health information in designated records that we or our business associates maintain, with some exceptions. To exercise your right of access, you need to complete the front side of this form. You may view these records or you may have a copy of the records. Please indicate your preference on the front side of this form.

Minnesota and Federal laws permit facilities to charge a reasonable fee for copies of medical records. Allina Hospitals and Clinics follow the fee schedule set by the Minnesota Department of Health. You or those authorized to receive the copies of records may be charged a fee for photocopies of records or copies of radiology films, videos, monitor tracings or other images (secondary records).

If you are the patient's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative.

Your signature authorizing disclosure of medical information (on the front side) indicates your review and understanding of the information described above.

You are entitled to a copy of this document.

PLEASE NOTE: ***An incomplete form cannot be accepted. If you have questions about completing this form, please contact the Health Information Department of the facility from which you intend to seek information. Records should be requested a reasonable time before they are needed and will be only released upon payment of the appropriate fee.***

For all hospitals listed below, this form must be delivered or mailed to **Attn: Health Information Department**

Abbott Northwestern Hospital / Sister Kenny Institute
800 East 28th Street
Minneapolis, MN 55407
612-863-4722

Abbott Northwestern also maintains old records for:
Abbott Hospital (pre 1979)
Northwestern Hospital (pre 1979)
Sister Kenny Institute
Lynville Hospital
Eitel Hospital
On-site Abbott Clinics

Buffalo Hospital
303 Catlin Street
Buffalo, MN 55313
763-682-1212

Mercy Hospital
4050 Coon Rapids Boulevard NW
Coon Rapids, MN 55433
763-236-6000

Owatonna Hospital
903 South Oak Avenue
Owatonna, MN 55060
507-451-3850

Phillips Eye Institute
2215 Park Avenue
Minneapolis, MN 55404
612-336-6000

Cambridge Medical Center
701 S. Dellwood
Cambridge, MN 55008
763-689-7700

River Falls Area Hospital
1629 East Division Street
River Falls, WI 54022
715-425-6155

St. Francis Regional Medical Center
1455 St. Francis Avenue
Shakopee, MN 55379
952-403-3915

New Ulm Medical Center
1324 5th Street North
PO Box 577
New Ulm, MN 56073
507-233-1000

United Hospital
Mail Stop 60239
333 North Smith Avenue
St. Paul, MN 55102
651-241-8000

United Hospital also maintains old records for:
Miller Hospital
St. Lukes's Hospital
Metropolitan Medical Center
Swedish Hospital
St. Barnabas Hospital
Metropolitan Mount Sinai
Mt. Sinai

Unity Hospital
550 Osborne Road NE
Fridley, MN 55432
763-236-5000