UNIVERSITY OF MINNESOTA
Boynton Health 410 Church Street S.E. Phone: 612-625-8400
boynton.umn.edu Minneapolis, MN 55455 Fax: 612-625-1434

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

My Information should be released FROM:(select only one)

☐ Boynton Health (*address/FAX above*)

☐ Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

My Information should be released TO: (select only one)

☐ Boynton Health (*address/FAX above*)

☐ Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Patient Identifying Information:

Name (Please print):_____

Date of Birth: _____ Patient ID# _____

Preferred Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Work:_____

How to Release (select only one**):**

☐ Mail the information to the address written above.

☐ Fax the information to the fax number written above.

☐ I or _____ (valid photo ID required) will pick up the records on _____. Allow one week unless other arrangements are made.

☐ Other (specify):_____

I authorized the release of:

☐ Printed copy of my records ☐ Form(s) **and/or** Letter(s).

☐ Other (explain) : ☐ Verbal exchange of information between parties.

☐ _____

The purpose of this release is: ☐ Continuing care.

☐ Other:_____

Information to be released: (select all that apply)

☐ **Specific Visit, Date(s)/Condition(s):**_____

☐ **Clinical records:** (specify)

☐ Clinic/Progress notes ☐ Radiology reports ☐ Billing/Finance records ☐ Eye Clinic Notes

☐ Laboratory/Pathology records ☐ EKG reports

☐ Immunizations. ☐ TB screening ☐ HIV/AIDS treatment ☐ Films/Slides/Images/CDs.

☐ **Dental Clinic records** ☐ **Dental xrays** ☐ **Psychiatric records** ☐ **Chemical Dependency/Substance Use Dis.**

☐ **Other**: _____

These records require specific consent for release and <u>may not be combined with any other consent on the same page</u>:

☐ Psychotherapy notes. ☐ Couples/Family Therapy - ***Each party must complete a separate form.***

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization will expire one year from the date of my signature unless a different expiration date is entered here:**_____
- I understand that once information is released pursuant to this authorization, Boynton Health cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- I understand that my treatment will not be conditioned on my signing this authorization except for research-related treatment.
- I understand that I am entitled to a copy of this *Authorization for the Release of Health Information*.

_____ _____ _____

Signature of Patient/Authorized Person | Authorized Person's authority to sign | Date

_____ REASON PATIENT CANNOT SIGN: ☐Minor ☐Deceased ☐Other:_____

Printed name of Authorized Person (legal name)

OFFICE USE ONLY

Fee

Received by:_____ Completed by: _____

Filed by:_____ Date sent: _____

rev 01/27/23