UNIVERSITY OF MINNESOTA
Boynton Health 410 Church Street S.E. Phone: 612-625-8400
boynton.umn.edu Minneapolis, MN 55455 Fax: 612-677-3211

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: Disability Resource Center
  Address: 180 McNamara Alumni Ctr, 200 Oak Street SE
  City: Minneapolis State: MN Zip: 55455
  Phone: 612-626-1333 Fax: 612-626-9654

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
- ☐ Other (explain) :
- ☐ _____
- ☒ Form(s) **and/or** Letter(s).
- ■ Verbal exchange of information between parties.

The purpose of this release is:

- ☐ Continuing care.
- ■ Other: Disability accommodation documentation

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
  - ☐ Immunizations.
  - ☐ TB screening
  - ☐ Laboratory/Pathology records
  - ☐ EKG reports
  - ☐ 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

_____ Printed name of Authorized Person (legal name)

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

OFFICE USE ONLY

Fee

Received by:_____ Completed by: _____
Filed by:_____ Date sent: _____

rev 01/27/23