

# 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 (Fax: 612-677-3211, address below)
- Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

- Boynton Health (Fax: 612-677-3211, address below)
- 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:

- Form(s) and/or Letter(s).  Printed copy of my records
- Verbal exchange of information between parties.  Other (explain): \_\_\_\_\_

The purpose of this release is:  Continuing care.  Other: \_\_\_\_\_

## Information to be released: (select all that apply)

- Clinical records: (specify):  Clinic/Progress notes  Radiology reports  Eye Clinic Notes  EKG reports
- Billing/Finance records  Laboratory/Pathology records  HIV/AIDS treatment  Films/Slides/Images/CDs
- Dental Clinic records  Immunizations  TB screening  Psychiatric records  Chemical Dependency/Substance Use Dis.
- Dental xrays  Other: \_\_\_\_\_
- Specific Visit, Date(s)/Condition(s): \_\_\_\_\_

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

- 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*.
- I understand that in the event of a medical emergency, my health records may be released to the provider(s) handling my emergency care without the completion of an Authorization for the Release of Medical Information form.

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: \_\_\_\_\_

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**BOYNTON HEALTH**  
UNIVERSITY OF MINNESOTA

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