

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Previous Names _____
Address _____
Birthdate _____ Phone Number _____ MR# _____

<p>PROVIDER [Who has the information that you would like released?]</p>	<p>Name: <u>Grand Itasca Clinic and Hospital</u> Address: <u>1601 Golf Course Road</u> <u>Grand Rapids, MN 55744</u> Phone: <u>(218)326-3401</u> Outgoing Fax: <u>(218)999-1513</u> Incoming Fax: <u>(218)999-1512</u></p>																
<p>REQUESTOR [Where do you want the information to be sent?]</p>	<p>Name: _____ Address _____ Phone: _____ Fax: _____ Delivery Preference: <input type="checkbox"/> Mail <input type="checkbox"/> Email _____ (Email Address) <input type="checkbox"/> MyChart <input type="checkbox"/> Fax <input type="checkbox"/> Onsite pick up</p>																
<p>INFORMATION TO BE RELEASED</p>	<table border="0"><tr><td><input type="checkbox"/> Clinic Notes</td><td><input type="checkbox"/> Discharge Summary</td></tr><tr><td><input type="checkbox"/> Immunizations</td><td><input type="checkbox"/> History and Physical</td></tr><tr><td><input type="checkbox"/> Exam Pathology Reports</td><td><input type="checkbox"/> Consultation Reports</td></tr><tr><td><input type="checkbox"/> X-ray/Radiology Reports</td><td><input type="checkbox"/> Lab Results</td></tr><tr><td><input type="checkbox"/> Films</td><td><input type="checkbox"/> Operative Reports</td></tr><tr><td><input type="checkbox"/> EKG/ ECHO Reports</td><td><input type="checkbox"/> Emergency Services</td></tr><tr><td colspan="2"><input type="checkbox"/> Other (please specify) _____</td></tr><tr><td colspan="2">Dates of Treatment or Condition _____</td></tr></table>	<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Immunizations	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Exam Pathology Reports	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> X-ray/Radiology Reports	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Films	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> EKG/ ECHO Reports	<input type="checkbox"/> Emergency Services	<input type="checkbox"/> Other (please specify) _____		Dates of Treatment or Condition _____	
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<p>REASON FOR RELEASE</p>	<table border="0"><tr><td><input type="checkbox"/> Continued care by another provider</td><td><input type="checkbox"/> Personal use</td></tr><tr><td><input type="checkbox"/> Attorney review</td><td><input type="checkbox"/> Insurance claim purposes</td></tr><tr><td colspan="2"><input type="checkbox"/> Other (please specify) _____</td></tr></table>	<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Personal use	<input type="checkbox"/> Attorney review	<input type="checkbox"/> Insurance claim purposes	<input type="checkbox"/> Other (please specify) _____											
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- ❖ With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here: _____
- ❖ I understand I may revoke this authorization by written request at any time to the address listed 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 automatically expire one year from the date of my signature, or _____ (period of time, for example 2 days, or 3 weeks, or 5 months) from my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.
- ❖ I understand there may be a retrieval and copy charge associated with the release.
- ❖ I understand that once information is released pursuant to this authorization, Grand Itasca Clinic & Hospital cannot prevent the re-disclosure of the information to another third party.
- ❖ I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
- ❖ Except for research-related treatment, Grand Itasca Clinic & Hospital will not condition treatment on my signing this authorization.

Signature of Patient / Authorized Person

Authorized Person's Authority to Sign
(Parent, guardian, power of attorney, etc.)

Date

Signed and completed release forms can be submitted via email to DEPT-GICH-ROI-TEAM@Fairview.org, faxed to 218-999-1513, or mailed to Grand Itasca Clinic and Hospital

If you have any questions, please call the Release of Information Desk at (218) 999 -1517