



H0784

**AUTHORIZATION TO RELEASE / REQUEST PROTECTED HEALTH INFORMATION**

**ALL AREAS IN RED MUST BE COMPLETED OR YOUR RELEASE WILL NOT BE VALID AND YOUR REQUEST WILL BE RETURNED OR DELAYED**

SL07  
914 SOUTH 8TH ST.  
MINNEAPOLIS, MN 55404

1	PATIENT NAME (LAST) (MIDDLE) (FIRST)	DATE OF BIRTH
	STREET ADDRESS	PHONE NO.
	CITY, STATE & ZIP CODE	

**PLEASE INDICATE WHO HAS THE RECORDS YOU WOULD LIKE RELEASED**

2	<input type="checkbox"/> <b>Hennepin Faculty Associates</b> ATTN: Release of Information 914 South 8th Street, SL07 Minneapolis, MN 55404 612-347-5284 FAX 612-337-7328	<input type="checkbox"/> <b>Hennepin County Medical Center</b> ATTN: Release of Information 701 Park Avenue Minneapolis, MN 55415 612-873-3179 FAX 612-904-4332	<b>IF OTHER LOCATION - PLEASE INCLUDE NAME AND ADDRESS</b> _____ _____ _____
	PLEASE NOTE HERE IF YOU WANT RECORDS RELEASED FROM A SPECIFIC PROVIDER OR CLINIC _____		

**3 INDICATE THE PURPOSE FOR THE RELEASE OF INFORMATION**

CONTINUED CARE     INSURANCE     ATTORNEY     SELF     OTHER \_\_\_\_\_

**4 DATE RANGE OF RECORDS YOU WOULD LIKE RELEASED** FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**5 SPECIFIC INFORMATION TO BE RELEASED:**

<input type="checkbox"/> Billing & Itemized Statements	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Dental records or x-rays	<input type="checkbox"/> Lab Report	<input type="checkbox"/> X-ray Films
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operation Reports	<input type="checkbox"/> Other _____
<input type="checkbox"/> EKG's	<input type="checkbox"/> Pathology Reports	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Physicians & Clinic Notes	

**By initialing here \_\_\_\_\_ I authorize Alcohol, Psychiatry or HIV related information to be released.**

**6 PLEASE INDICATE WHERE YOU WOULD LIKE RECORDS SENT**

6	<input type="checkbox"/> <b>Hennepin Faculty Associates</b> ATTN: Release of Information 914 South 8th Street, SL07 Minneapolis, MN 55404 612-347-5284 FAX 612-337-7328	<input type="checkbox"/> <b>Hennepin County Medical Center</b> ATTN: Release of Information 701 Park Avenue Minneapolis, MN 55415 612-873-3179 FAX 612-904-4332	<b>IF OTHER LOCATION - PLEASE INCLUDE NAME AND ADDRESS</b> _____ _____ _____
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- I understand that this authorization is valid for one year and that HFA will only release records up to the date signed unless otherwise noted.
- I understand that this authorization may be revoked by a written statement sent to one of the facilities listed above.
- I understand that the revocation will not apply to information that has already been released in response to the authorization.
- I understand that once the information is released pursuant to this authorization the redisclosure of the information to another third party cannot be prevented.
- I understand that my treatment will not be conditioned on my signing this authorization and a photocopy will be treated in the same manner as an original.

7	SIGNATURE OF PATIENT/AUTHORIZED PERSON	DATE
	RELATIONSHIP TO PATIENT	REASON PATIENT IS UNABLE TO SIGN