HealthPartners
Release of Information Services
Mail Stop 25510C
PO Box 1490
Minneapolis, MN 55440-1490
Telephone: 651-265-1640
Facsimile: 651-265-1630

HealthPartners ROIS Use Only

MRN_____

Completed By_____ Date_____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	Name:_____Previous_____ Date of Birth:_____ Daytime Telephone #_____ Address:_____ City:_____State:_____Zip:_____
Health Information Released **FROM**	☐ HealthPartners Clinics ☐ Other Provider/Person/Organization_____ Address:_____ City:_____State:_____Zip:_____
Health Information Released **TO**	Person/Organization: (If copies are requested include COMPLETE address) Well@Work Robbinsdale Schools 8301 47th Ave North New Hope, MN 55428
Purpose of Disclosure	☐ Continuity or Transfer of Care ☐ Consultation ☐ Disability ☐ Insurance ☐ Legal/Attorney ☐ Payment ☐ Personal ☐ Other (Please Explain)_____
Health Information to be Released	☐ **Copies of Records** ☐ **Verbal Exchange (no copies)** ☐ Entire Health Record (includes all records listed) ☐ Office Notes ☐ Laboratory results ☐ Immunization Record ☐ History and physical report ☐ X-ray/imaging results ☐ Allergy records ☐ Clinic Procedure/operative report ☐ Appointment Information ☐ Medication information ☐ Consultation report (doctor, date)_____ ☐ Eye/Optical records ☐ Behavioral (Mental) Health ☐ Chemical Health Records ☐ Radiology image film/CD ☐ Dental Records (Please give request to your Dental Clinic for this release) ☐ Other described here:_____ *Unless specifically excluded, behavioral/mental health information, HIV information, and/or alcohol/drug abuse information appearing in the information selected above will be disclosed.* ***Do not release records/information related to:*** *□ Behavioral/Mental Health □ HIV/HIV related illnesses □ Alcohol and/or drug abuse* **There may be a charge for copies of your records per Minnesota Statute 144.292.**
Method of Delivery	☐ Mail to Recipient ☐ Pick up on ___/___/___ Picture ID is required when picking up records. ☐ Fax to: _____ATTN:_____ ☐ Other:_____
Authorization	**This authorization expires (ends) on the following date, event, or condition:_____** This authorization will expire no more than twelve (12) month from the date I sign this form unless otherwise specifically permitted by law. **I understand that:** ● I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in the FROM section. ● Revoking this authorization does not apply to information that has already been released under this authorization. ● I have the right to inspect or obtain a copy of the health information disclosed. ● If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed. ● I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company. _____ _____ *Signature of Patient or Patient's Representative* *Signature Date* _____ _____ *Print name of Representative* *Relationship to patient* _____ _____ *Signature of Witness* *Print name of witness*