NEIGHBORHOOD healthsource

Health care with a heart, close to home!

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This document provides the authorization for the release of information as indicated below. Information about you cannot be released to others without your consent, except as authorized by law. Do not sign this release unless it is completed and in your best interests.

Patient / Client Information	Name: _____ Date of Birth: _____ Address: _____ City: _____ State:_____ Zip:_____ Phone #: _____
Releasing Party (*Who* do you want to send the information)	Organization Name: _____ Address: _____ City: _____ State:_____ Zip:_____ Phone #: _____ Fax #:_____
Receiving Party (*Where* do you want the information sent?)	Organization Name: _____ Address: _____ City: _____ State:_____ Zip:_____ Phone #: _____ Fax #:_____
Information to be Released (*What* do you want sent or released?) IMPORTANT: Indicate only the information that you are authorizing to be released.	For the Following Date(s) of Treatment: _____ OR [ ] All Dates of Treatment [ ] Progress Notes [ ] Immunizations [ ] Consultant Reports [ ] Laboratory Reports [ ] History and Physical / Initial Evaluation [ ] Inpatient Records / Discharge Summary [ ] X-ray Reports [ ] Treatment Plan [ ] Other: _____ <u>Requires special consent by law for release:</u> [ ] HIV / STD Testing [ ] Mental Health Records [ ] Psychological Testing [ ] Psychotherapy Notes [ ] Substance Abuse Records
Release Instructions (*How* and *When* do you want the information?)	Release Method / Format requested: (check one) [ ] Mail [ ] Patient Pick Up (ID will be requested at the time of pick up) [ ] Fax (Patient Care Only)
Purpose of Release (*Why* is it needed?)	[ ] Insurance / Benefits [ ] Continuity of Care [ ] Legal* [ ] Personal Use or Review* [ ] Other* * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Neighborhood HealthSource Notice of Privacy Practice describes how to cancel (revoke) this authorization. Neighborhood HealthSource will not restrict my treatment if I choose not to sign this authorization. Neighborhood HealthSource cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Neighborhood HealthSource from any and all liability resulting from a re-disclosure by the recipient. Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Signature of Patient / Client / Legal Guardian Relationship Date

Internal Use Only

Form Completed By: _____ Information Request Completed By: _____

Date: _____ Date: _____