University of Minnesota
Medical Center, Fairview

University of Minnesota
Children's Hospital, Fairview

Health Information Management Services

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Patient Name _____ **Medical Record #** _____
(please print clearly) (for office use only)

Previous Names _____ **Social Security #** _____ **Birthdate** ___/___/___
(optional)

Phone Numbers (Home) _____ **(Work)** _____ **(Other)** _____

Release Records **FROM:**	☐ **University of Minnesota Medical Center, Fairview/University of Minnesota Children's Hospital, Fairview** *or* **Clinic/Organization Name:** _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____ ☐ **If records are being released to self, please check here if you want the envelope marked "Personal and Confidential."**
Release Records **TO:**	☐ **University of Minnesota Medical Center, Fairview/University of Minnesota Children's Hospital, Fairview** *or* **Person/Clinic/Organization Name:** _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____
Information to be Released/ Reviewed:	**The following information is to be released (check appropriate boxes):** ☐ Discharge Summary ☐ Pathology Reports ☐ Operative Reports ☐ Counselor's Discharge Summary ☐ Pathology Slides ☐ EKG/ECHO Reports ☐ History and Physical Exam ☐ Laboratory Reports ☐ Emergency Dept. Reports ☐ Consultation Reports ☐ Radiology Reports ☐ Psychological Tests ☐ Outpatient Clinic Notes ☐ Films/CD ☐ Pertinent Information ☐ Other (specify) _____ **For the following date(s) of treatment or condition:** _____ (Specify dates of treatment or condition)
Reason for Disclosure:	**I would like this information released for the following purpose:** ☐ Continued care by another provider ☐ Insurance purposes ☐ Personal use ☐ Attorney ☐ Social Security Disability ☐ Other _____

I have read and understood the following:

- Except for psychotherapy notes (these notes are not included in my medical record), Fairview will release all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. If I don't want these to be released, I will place a checkmark here: _____. I do not want the following records released: _____
- If I change my mind, I may write to the address at the top of this form to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it or sooner (specify here: _____). The time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records.
- Once the records are released, Fairview cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless the treatment is part of a research project that requires this authorization.

_____ _____ _____
Signature of patient or authorized person (If authorized person is signing, please also print name) | **Authorized person's authority to sign** (parent, guardian, power of attorney, etc.) | **Date**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION