University of Minnesota Physicians
Authorization for Release
of Protected Health Information

Office use only MR#_____

Print patient's legal name: _____ Birth date: ____/____/____
Previous name(s):_____ Phone: _____

1. **Please release my records from:** *(Who has your records? Please list the specific provider and/or clinic.)*
   Name: _____
   Phone:_____ Fax: _____
   Address:_____ City:_____ State:_____ Zip:_____

2. **Release the records marked below for this condition or date(s) of treatment:** _____
   (if blank, we will release 1 years' worth of most recent records.)
   ☐ Clinic Record Set (office visit, lab/radiology, medications, immunizations)
   ☐ Immunization records ☐ X-ray/Radiology films/CDs ☐ EKG/ECHO Reports
   ☐ Lab/Pathology reports ☐ X-ray/Radiology Reports ☐ EEG ☐ Office Visit
   ☐ Other (please specify): _____

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: _____
   Phone:_____ Fax:_____
   Address:_____ City:_____ State: _____ Zip:_____

4. **Delivery/format:** ☐ Paper copy ☐ CD ☐ Mail ☐ Fax ☐ Will pick up _____
   ☐ E-mail address: _____ **Date needed by:** _____
   ☐ MyChart patient portal (secure - requires existing MyChart account)
   ☐ E-mail address (Non-secure): _____

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other _____

6. **I understand that:**
   - Except for psychotherapy notes (not included in medical record), the release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released**: _____
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - I approve the release of records for future visits, starting from the date I sign this form through:_____.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - If I do not sign this form, I will still get medical treatment, unless treatment is part of a research project.
   - This form expires one year after I sign it, or on _____, except in certain situations specified by law.

_____	_____	_____	_____
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and description of authority to sign for patient (may require proof)***

Directions for Completing the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Use clear handwriting.

Patient Information section: This is about the patient who needs medical records. Please fill it out completely.

Section 1 - Release records from: Write down which clinic, hospital or facility has the medical records.

Section 2 - Records to be released *(Important: If the information you identify includes sensitive information you do not want to release, you can exclude that information in section 6.):*

- **For condition or dates of treatment:** Write down the condition or dates of treatment.
- Mark the box next to the information you want released. Check "other" to request any records not listed. Please specify which records you need.

Section 3 - Please release my records to: Write down your name or the name of another person, healthcare facility or organization that needs the medical records. (Please note: it is UMP's policy NOT to fax or e-mail patient information except for direct patient care needs or by patient request, such as to a hospital or clinic.)

Section 4 - Delivery/format: Mark how you would like the records to be prepared and delivered. The MyChart patient portal is a secure electronic delivery option for patients who provide their personal e-mail address. For additional questions regarding MyChart, call 855-513-5513.

Section 5 - Purpose: Mark why you need a copy of the records. This will help track your request and assign priority status, if needed. It also informs us who may be responsible for the cost of records (when appropriate).

Section 6 – I understand: Read the bulleted items. This consent will expire (end) in 12 months unless you write in a different date. You may **stop** or **revoke** (take back) your consent by writing us. Sign and date the form, and include the time. If you are signing the document on behalf of the patient, proof of your legal authority may be requested. Proof examples: Power Of Attorney (POA) for Healthcare, Advance Care Directive and court appointed Legal Guardianship documents.

Contact Information for Release of Information:

University of Minnesota Physicians
720 Washington Ave SE, Suite 200
Minneapolis, MN 55414
Phone: 612-884-0650
Fax: 612-884-0907

Utilize this Authorization form if you were seen by a University of Minnesota Physician at one of the following clinics:

Bethesda Family Medicine Clinic
Bierman Clinic
Broadway Family Medicine
Center for Sexual Health
Developmental Behavioral Peds
Mill City
MINCEP
Minneapolis Eye
Neurospecialty Clinics at St Louis Park
Nurse Practitioner Clinics
Pediatric Specialty Clinic - Woodbury
Phalen Village
Psychiatry Specialty Clinics at St Louis Park
Reproductive Medicine (Closed)
Smiley's Family Medicine
St. Paul Neurology (Closed)

If you were seen at:
University of Minnesota Medical Center & University of Minnesota Masonic Children's Hospital & University of Minnesota Health Clinics and Surgery Center or a Fairview Clinic

Please contact:

Fairview Metro Area Hospitals
Release of Information, LL25
6401 France Ave. S
Edina, MN 55435-2199
Phone: 952-924-5165
Fax: 952-924-8443

For other locations, please visit www.fairview.org/medical-records

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