AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION/PATIENT REQUEST FOR ACCESS TO PATIENT HEALTH INFORMATION

Patient Name (Last, first, middle initial) Social Security #

Street Address City State Zip

Date of Birth Day Phone # Evening Phone #

INFORMATION RELEASED FROM	**INFORMATION RELEASED TO/EXCHANGED WITH**
(Name of Staff Member or Department)	Name (Hospital, clinic, attorney, insurance company, individual)
(Facility name and address)	Street Address
	City State Zip
	Date Information Needed

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

Medical Condition/Specify Injury

Approximate Visit Dates ☐ View Record ☐ Receive Copy

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

☐ Discharge Summary ☐ Operative Report ☐ Laboratory Report(s) ☐ Emergency Record(s) ☐ Clinic Visit Notes

☐ Radiology Reports ☐ Consultation(s) ☐ Chemical Dependency/Drug or Alcohol Abuse Treatment Records

☐ Radiology Films ☐ History and Physical ☐ Pathology Report ☐ Billing Records/Statements (date) _____

☐ Secondary Records (specify film/video/monitor tracings) _____ ☐ Other _____

-OR-

☐ Any and all medical records (including billing records and secondary, chemical dependency/drug or alcohol abuse treatment records

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH AND/OR HIV/HIV RELATED ILLNESSES WILL BE RELEASED UNLESS INDICATED HERE:

☐ DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

☐ Patient Access ☐ Insurance Application ☐ Social Security Documentation ☐ Social Security Disability Appeal

☐ Litigation ☐ Continuing Care ☐ Insurance Payment

☐ Other (please specify) _____

Authorization expiration date or event:_____(If left blank, will expire one year from date of signature)

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. **UFM will <u>not</u> refuse or restrict my treatment if I choose not to sign this authorization.** A photocopy of this authorization will be treated in the same manner as the original.

Further, I realize that UFM cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections, therefore UFM is released from any and all liability resulting from disclosure. I have read and understand my rights as described on the back of this form.

_____ _____

Patient/Legal Representative Signature Date Authority to Act on Behalf of Patient (attach document)

Information released by Nursing Station/Other/Verbally ☐ No ☐ Yes By _____ Date _____

PLEASE READ THE FOLLOWING INFORMATION

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

You have the right to inspect and obtain a copy of your protected health information in designated records that we or our business associates maintain, with some exceptions. To exercise your right of access, you need to complete the front side of this form. You may view these records or you may have a copy of the records. Please indicate your preference on the front side of this form.

Minnesota and Federal laws permit facilities to charge a reasonable fee for copies of medical records. UFM follows the fee schedule set by Minnesota Department of Health. You or those authorized to receive copies of records may be charged a fee for photocopies of records or copies of radiology films, videos, monitor tracings or other images (secondary records).

If you are the patient's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative.

Your signature authorizing disclosure of medical information (on the front side) indicates your review and understanding of the information described above.

You are entitled a copy of this document.

PLEASE NOTE: An incomplete form cannot be accepted. If you have questions about completing this form, please contact the Health Information Department of the facility from which you intend to seek information. Records should be requested a reasonable time before they are needed and will be only released upon payment of the appropriate fee.