University of Minnesota Physicians
720 Washington Ave SE, Suite 200
Minneapolis MN, 55414

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ **MRN:** _____
for office use only

Address: _____ **Date of Birth:** _____

_____ **Telephone:** _____

Information to be Released From:	**Information to be Released To:**
Doctor/Clinic Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone Number: _____	Phone Number: _____

Information to be released (MUST CHECK ALL THAT APPLY):

☐ History & Physical	☐ X-Ray/Radiology Reports	☐ ECHO Reports
☐ Progress Notes	☐ EKG Reports	☐ Billing Information
☐ Lab Reports	☐ EEG Reports	☐ Other _____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____

Please indicate any restrictions. (Specify) _____

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

☐ Continued Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other: _____

Information will be mailed unless otherwise stated here: _____

- I understand I may revoke this authorization by written request at any time to the address listed at the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once information is released pursuant to this authorization, UMPhysicians cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- Except for research-related treatment, UMPhysicians will not condition treatment on my signing this authorization.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

_____ _____ _____
Signature of Patient/Legal Representative **Date** **Time**

_____ _____
Print Name of Legal Representative (if applicable) **Legal Representative's authority to sign**
(parent, guardian, health care power of attorney, etc.)

REASON PATIENT IS UNABLE TO SIGN: ☐ **MINOR** ☐ **DECEASED** ☐ **OTHER:** _____