Regions Hospital®
HealthPartners®

640 Jackson Street
St. Paul, MN 55101
Mailstop: 11501E
Telephone 651-254-2468
Facsimile 651-254-2836

Regions Hospital Use Only
MRN_____
Release ID_____

# PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

**Patient Information**

Patient Name _____ Patient Former Name _____
Date of Birth _____ Patient Phone (____) ____ – ____
Address _____ City _____ State _____ Zip _____

**Health Information Released FROM**

☐ Regions Hospital and Regions Clinics
☐ Other _____
Address _____ City _____ State _____ Zip _____

**Health Information Released TO**

Individual Name _____ Phone (____) _____
Organization Name _____ Fax # (____) _____
Address _____ City _____ State _____ Zip _____

**Purpose of Disclosure**

☐ Continuity of Care ☐ Insurance ☐ Personal
☐ Disability ☐ Legal/Attorney ☐ Other (Please Explain) _____

**Health Information to be Released**

☐ **Copies of Records** ☐ **Verbal Exchange (no copies)**
☐ Entire Health Record (initial here) _____
☐ Hospital admission (date) _____ ☐ Emergency room visit (date) _____ ☐ Clinic Visit (date) _____
☐ History and physical report ☐ Laboratory results ☐ Consultation Report
☐ Procedure / operative report ☐ X-ray / imaging results ☐ Discharge summary
☐ Medication administration report ☐ Radiology image film / CD ☐ Discharge instructions
☐ Other (described here) _____

*Unless specifically excluded, behavioral health/mental health information and/or HIV information appearing in the information selected above will be disclosed. Please exclude:* _____

If initialed here _____, my chemical health treatment program record may be disclosed.

**Method of Delivery**

☐ Mail to Recipient ☐ Pick up on ____/____/____ (photo ID required at pick-up)
☐ Fax to: _____ ☐ Other: _____

**Authorization**

**This authorization expires (ends) on the following date, event or condition:** _____
This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law.

**I understand that:**

- I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in Section 1 above.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or obtain a copy of the health information to be disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company.

_____ _____ _____
*Signature of Patient or Patient's Representative* *Signature Date* *Time*

If signed by patient's representative:

_____ _____
*Print name of representative* *Relationship to patient*

_____ _____
*Signature of Witness* *Print name of witness*