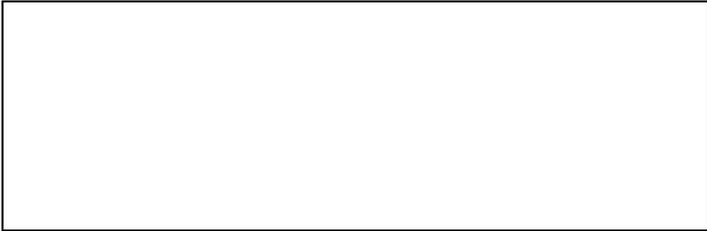




**HealthEast Hospitals Release of Information Services**  
**University Park Medical Building Suite 180**  
**1690 University Ave W**  
**St Paul, MN 55104 Phone: 651-232-4999 Fax: 651-232-4887**



**I Hereby Authorize HealthEast**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Bethesda Hospital<br>559 Capital Blvd St. Paul, MN 55103       | <input type="checkbox"/> St John's Hospital<br>1575 Beam Ave Maplewood, MN 55109     | <input type="checkbox"/> St. Joseph's Hospital<br>45 West 10 <sup>th</sup> St. St. Paul, MN 55102             | <input type="checkbox"/> Woodwinds Health Campus<br>1925 Woodwinds Dr. Woodbury, MN 55125 |
| <input type="checkbox"/> Midway Surgery Center<br>1700 University Ave St Paul, MN 55104 | <input type="checkbox"/> Midway Pain Center<br>1700 University Ave St Paul, MN 55104 | <input type="checkbox"/> HealthEast Medical Imaging<br>3640 Talmage Circle Ste. 100, Vadnais Heights MN 55434 | <input type="checkbox"/> Other _____<br>Phone: 651-471-8000 Fax: 651-471-8080             |

**TO REQUEST information FROM:** \_\_\_\_\_

Facility name and address → \_\_\_\_\_

<b>Send requested information to:</b> <b>Location:</b> _____ <b>Attn:</b> _____ <b>Fax #</b> _____ *Faxing for patient care needs only
--

**I Hereby Authorize HealthEast \_\_\_\_\_ to RELEASE information TO:**  
 (Select from above)

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

**Regarding the Following Patient:**

Patient Name \_\_\_\_\_ Phone # \_\_\_\_\_

Other Names \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

**Records to be released:** \_\_\_\_\_ **Date(s) treatment was received:** \_\_\_\_\_

- |  |   |   |                                      |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Consultation Report   | <input type="checkbox"/> Laboratory Report    | <input type="checkbox"/> Radiology                                    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Operative Report     | <input type="checkbox"/> Test Results                                 |                                      |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Pathology Report     | <input type="checkbox"/> Photographs, Videos, Digital or Other Images |                                      |
| <input type="checkbox"/> History and Physical  | <input type="checkbox"/> Radiology Image Film |   |                                      |

I authorize the release of information relating to:  HIV/AIDS Testing/Treatment  
 Psychiatric Evaluation/Treatment  Alcohol/Drug Abuse Evaluation/Treatment  Genetic Testing/Evaluation

**Purpose of Release:**  
 Continuing/Transfer of Care  Insurance  Litigation  Personal Use  Other \_\_\_\_\_

**This authorization expires on the following date, event or condition:** \_\_\_\_\_

If I do not specify any expiration date, event or condition, this authorization will expire in one year.

**Statement of Authorization:**

- I understand that, except for research related treatment, HealthEast will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Management (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

\_\_\_\_\_  
 Signature of Patient/Legally Authorized Representative Date

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Reason Patient Unable to Sign

\_\_\_\_\_  
 Signature of Witness (Verbal Authorization Only)

\_\_\_\_\_  
 Signature of Witness (Verbal Authorization Only)

-----**For HealthEast Use Only**-----

Medical Records Released By: \_\_\_\_\_ Date: \_\_\_\_\_ MR# \_\_\_\_\_  
 Copies  Review

