UNIVERSITY OF MINNESOTA
Boynton Health
www.bhs.umn.edu
410 Church Street S.E.
Minneapolis, MN 55455
Phone: 612-625-8400
BH Fax: 612-625-1434
MCTC Fax: 612-659-6399

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

My Information should be released FROM: (select only one)

☐ Boynton Health Service (*address/FAX above*)
☐ Name:____________________
Address:____________________
City:__________ State:_____ Zip:______
Phone:__________ Fax:__________

My Information should be released TO: (select only one)

☐ Boynton Health Service (*address/FAX above*)
☐ Name:____________________
Address:____________________
City:__________ State:_____Zip: ______
Phone:__________ Fax:__________

Patient Identifying Information:

Name (Please print): ____________________
Date of Birth:________________
Patient #:________________
Address:____________________
City:__________ State:_____ Zip:______
Phone:__________ Work:__________

How to Release (select only one**):**

☐ Mail the information to the address written above.
☐ Fax the information to the fax number written above.
☐ I or ________________ (valid photo ID required) will pick up the records on ________. Allow one week unless other arrangements are made.
☐ Other (specify):____________________

I authorized the release of:

☐ Printed copy of my records.
☐ Form(s) **and/or** Letter(s).
☐ Verbal exchange of information between parties.
.
☐ Other (explain) : ______________________________

The purpose of this release is:
☐ Continuing care.
☐ Other:______________________________

Information to be released: (select all that apply)

☐ **Specific Visit, Date(s)/Condition(s):**____________________
☐ **Clinical records:** (specify)

☐ Clinic/Progress notes ☐ Radiology reports ☐ Laboratory/Pathology records ☐ EKG reports
☐ Immunizations. ☐ TB screening ☐ HIV/AIDS treatment ☐ Films/Slides/Images/CDs.

☐ **Dental clinic records** ☐ **Dental xrays** ☐ **Psychiatric records** ☐ **Chemical Dependency Treatment**
☐ **Other**: ______________________________

These records require specific consent for release and __may not be combined with any other consent on the same page__:

☐ Psychotherapy notes. ☐ Couples/Family Therapy - ***Each party must complete a separate form.***

- I understand that I may revoke this authorization by written request at any time to the address at the top 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 expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party.
- 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 for continuing care.
- I understand that my treatment will not be conditioned on my signing this authorization except for research-related treatment.
- I understand that I am entitled to a copy of this *Authorization for the Release of Health Information.*

____________________ ____________________ ____________________
Signature of Patient/Authorized Person — Authorized Person's authority to sign — Date

____
Printed name of Authorized Person

REASON PATIENT CANNOT SIGN: ☐Minor ☐Deceased ☐Other:__________

OFFICE USE ONLY

Fee

Received by:____________________ Completed by: ____________
Filed by:____________________ Date sent: ____________

rev 03/15/16