

ALLINA HEALTH AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State _____ Zip: _____
Clinic/Hospital/Health Care Provider - <i>(Who has the information you want released?) Please list the specific Hospital and/or clinic.</i>	NAME: <u>Richard Sethre, L.P.</u> Address: <u>1405 Lilac Av. N., #160F</u> Day Phone: <u>612-460-0692</u> City: <u>Golden Valley</u> State <u>MN</u> Zip: <u>55422</u> <u>(Mental Health Professional)</u>
Receiving Party <i>(Where do you want the information sent? Who may have the information?)</i>	NAME: _____ Attention to: _____ Address: _____ Day Phone: _____ City: <u>(if known)</u> State _____ Zip: _____ Fax Number <u>(URGENT PATIENT CARE ONLY)</u> _____
Information to be Released <i>(What do you want sent or released? Check the appropriate box.)</i>	Routine Record Sets (indicate date(s) of service _____) <input type="checkbox"/> Clinic (office visit, lab, radiology, medicines, immunizations) <input type="checkbox"/> Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) <input type="checkbox"/> Billing Records <input type="checkbox"/> Copies of Films/Images <input type="checkbox"/> Community Pharmacy Charges <input type="checkbox"/> Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.) Only records types checked below: <input type="checkbox"/> Discharge summary/note <input type="checkbox"/> Radiology reports <input type="checkbox"/> Emergency record(s) <input type="checkbox"/> Medication records <input type="checkbox"/> History & physical exam <input type="checkbox"/> Rehab records (PT/OT/ST) <input type="checkbox"/> Immunization/allergy record <input type="checkbox"/> Chemical dependency/ <input type="checkbox"/> Operative report <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Pathology reports Substance abuse records <input checked="" type="checkbox"/> Consultations <input type="checkbox"/> Progress notes/clinic notes <input type="checkbox"/> Mental health records <input type="checkbox"/> Pathology slides/blocks <input checked="" type="checkbox"/> Other records specify record type(s) <u>see - summary assessment report</u> OPTIONAL Limits - Disclose only records related to following: Date(s) of service: _____ injury or illness: _____
Release Instructions <i>(How and When do you want the information?)</i>	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) Release Method / Format requested: (check one) <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> View my Record <input checked="" type="checkbox"/> Fax (patient care only) <input type="checkbox"/> Verbal Continuing Care Information released by Nursing Station/Department (verbal and paper) <input type="checkbox"/> Yes <input type="checkbox"/> No
Purpose of Release <i>(Why is it needed?)</i>	<input type="checkbox"/> Continuing care <input type="checkbox"/> Transfer of care <input type="checkbox"/> Social security appeal <input type="checkbox"/> Insurance application * <input type="checkbox"/> Personal use or review * <input type="checkbox"/> Social security disability determination * <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Litigation/legal * <input checked="" type="checkbox"/> Other* <u>see - summary assessment report</u> * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524
<ul style="list-style-type: none"> • This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____ • This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Allina Health Notice of Privacy Practice describes how to cancel (revoke) this authorization. • Allina Health will not restrict my treatment if I choose not to sign this authorization. • A photocopy/fax of this authorization will be treated in the same way as an original. • Allina Health records may include records that it received from other organizations. If these records have been used by Allina Health and filed in the record Allina Health maintains about you, these records may be released with your Allina Health records. • Allina Health cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Allina Health from any and all liability resulting from a redisclosure by the recipient. • Your signature indicates that you have read and understand this form, and authorize release of your information as described above. 	

Patient/Legal Guardian Signature _____

Date _____

Authority to act on behalf of patient (attach document) _____

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