Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

- Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.
- 2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section.

 Completing this section is optional.
- In this section, state who is sending your health information. Please be as specific as possible. If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.
- 4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information.

 Providing a date is optional.
- 5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information.

This helps prevent others from changing your form.

EXAMPLE: All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For** the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.

- 6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.
- **7** Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.
- **8** This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."
- Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.





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PAGE 1 OF 2

1	Patient information					
	First name	Middle name		Last name		
	Patient date of birth / /	Previous name(s)				
	Home address					
	City		State	Zip code		
	Daytime phone		E-mail addre	ess (optional)		
	Medical Record/patient ID number (option	al)				
_ 2	Contact for information about how this form was filled out (optional):					
	I give permission for the organization(s) listed in section 3 permission to talk to					
				about how this form was completed		
				address (optional)		
3				at least one of the following:		
J	Organization(s) name	illiation be relea	aseu mom	at least one of the following.		
	Specific health care facility or location(s)	(CLINIC)				
	Specific health care professional's name(s	. / [] []				
4	l am requesting that health information be sent to:					
	Organization(s) name AUBURN MEADOWS					
	And/or person: First name ADMISSI		Last name _			
	Mailing address 591 CHERRY DR		N 4 N 1	55007		
				Zip code 55387		
	Phone (optional) <u>952-442-6628</u>		_ Fax (optiona	952-442-6726		
	Information needed by (date)//	(optional)				
5	Information to be released					
	MPORTANT: indicate only the information that you are authorizing to be released.					
	☐ Specific dates/years of treatment					
	All health information (see description in instructions for what is included)					
	OR to only release specific portions of your health information, indicate the categories to be released:					
	✓ History/Physical	Mental health		☐ HIV/AIDS testing		
	✓ Laboratory report	Discharge summary	V	Radiology report		
	✓ Emergency room report	Progress notes	j	Radiology image(s)		
	☐ Surgical report	Care plan		Photographs, video, digital or other images		
	✓ Medications	Immunizations		Billing records		
	Other information or instructions	IIIIIIIIIIIIII		Billing records		
			_			
	The following information requires special consent by law. Even if you indicate all health information, you must specifically					
	request the following information in order for it to be released:					
	Chemical dependency program (see definition in instructions)					
	Psychotherapy notes (this consent cannot	t be combined with any other; s	see instructions)	THESO		
				S. D. S.		

Pa	atient's name	PAGE 2 OF 2			
3	Health information includes written and oral information By indicating any of the categories in section 5, you are giving permission for written information to be released and for a person i section 3 to talk to a person in section 4 about your health information.				
	If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your indicate that here (check mark or initials)	health information,			
7	Reason(s) for releasing information ✓ Patient's request ✓ Review patient's current care ✓ Treatment/continued care ☐ Payment ☐ Insurance application ☐ Legal ☐ Appeal denial of Social Security Disability income or benefits ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount) ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES) ☐ Other (please explain)				
3	I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to in section 4.	the third party named			
	I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in sec	ction 3.			
	If the organization, facility or professional named in section 3 has already released health information based on my to stop will not work for that health information.	consent, my request			
	I understand that when the health information specified in section 5 is sent to the third party named in section 4, the be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.	ne information could			
	I understand that if the organization named in section 4 is a health care provider they will not condition treatment, or eligibility for benefits on whether I sign the consent form.	payment, enrollment			
	If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment.				
	This consent will end one year from the date the form is signed unless I earlier date or event here: Date/ / Or specific event				
)		e//			
	Patient's signature Dat OR legally authorized representative's signature Dat	re/			
	Representative's relationship to patient (parent, guardian, etc.)	RINT FORM			

