Patient Authorization for Release of Protected Health Information

Internal Use Only	
	MRN ______
	Completed by ______ Date ______
	Release ID ______

Instructions for completing and mailing this form are on page 2.

Patient Information	Patient name			Previous last name (if any)
	Street address			Date of birth
	City	State	ZIP code	Phone number

Who has the information you want released?	Hospital/Clinic/Person	Phone number	Fax number	
	Street address	City	State	ZIP code

Where do you want the information sent?	Person/Business/Hospital/Clinic RECORDS DEPOSITION SERVICE, INC.	Phone number 312-553-8900	Fax number 312-553-8901	
	Street address 120 W. MADISON ST., SUITE 300	City CHICAGO	State IL	ZIP code 60602

Information to be sent (*check all that apply*) (*see instructions on back of form*)

I want my records related to ➤ PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

I want my records for dates of service ➤ ______ ☐ Future dates that apply to related care

☐ Clinic visit (includes provider note, lab results, imaging report, med list, immunizations)
☐ Hospital care (includes emergency dept. note, history & physical, operative report, lab results, imaging report, discharge summary)

I only want individual documents related to ➤ ______

I only want individual documents for dates of service ➤ ______ ☐ Future dates that apply to related care

- ☐ Provider note/clinic visit
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Eye or Optical
- ☐ Medication list
- ☐ Lab or Pathology report
- ☐ Pathology glass slides
- ☐ X-ray/Imaging report
- ☐ X-ray/Imaging CD (describe) ______
- ☐ Emergency department notes
- ☐ History and Physical
- ☐ Consult report
- ☐ Immunization
- ☐ Mental health record
- ☐ HealthPartners Dental (give request to your dental clinic)
- ☐ Billing or Itemized statements ➤☐ Paper ☐ CD (*Park Nicollet only*)
- ☐ Other ______

In compliance with federal law, special permission is required to release the following records:
☐ Programs for Change ☐ Alcohol and Drug Abuse Program

WISCONSIN RECORDS ONLY: Special permission is required to release the following records.
☐ HIV test results ☐ Mental Health ☐ Developmental Disability ☐ Substance use disorder

Purpose for release

☐ Continuity of care ☐ Personal/My request ☐ Disability ☐ Other FOR DISCOVERY BEFORE TRIAL
☐ Transfer of care ☐ Insurance ☑ Legal

Release method (*choose one*)

Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information.

➤ Date records needed (appointment date) ____ / ____ / ____

Paper ➤ ☐ Mail
☐ Fax ➤ Number ______
☐ Pick up ➤ Date ____ / ____ / ____

Electronic ➤ ☐ CD
☑ Secure email➤ *Indicate email address **ONLY** if you want your records sent via email. **Email may be sent by copy service.***
➤ Email address ILREQUESTS@RECDEP.COM

Authorization and Revocation

- I authorize the HealthPartners Family of Care to release the information marked above. HealthPartners Family of Care will not withhold treatment or insurance payment based on whether I sign this form. I have the right to a copy of this form, and to inspect or obtain a copy of the health information disclosed.
- Records released may include information received from other organizations.
- Records released may no longer be protected by law and could be redisclosed by the recipient.
- **There may be a charge for records.**
- This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified.➤ ______
- I may revoke this authorization by sending a written request to the appropriate HealthPartners Release of Information department (see section 8 on back of form). The revocation will take effect upon receipt.
- A photocopy/fax of this authorization will be treated in the same way as an original.

Patient signature	Date
If other than patient, state relationship and authority to sign	

Any changes to this form must be reviewed and approved by Health Information Management

900514 (03/17)