INDIAN HEALTH BOARD OF MPLS- 1315 E. 24TH STREET MPLS, MN 55404
PHONE- 612-721-9800 FAX- 612-721-2904
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	**NAME:** _____ **DATE OF BIRTH:** _____
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?)	**NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone Number:** _____
Receiving Clinic (**Who** will the information be sent to?)	**NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone Number:** **Fax Number:**
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	**Medical: Dates of Service** _____ ☐ Progress notes/clinic notes ☐ Diagnostic Test Reports ☐ Radiology Reports ☐ Emergency record(s) ☐ Obstetrics Records ☐ Operative report ☐ Lab Report(s) ☐ History & Physical exam ☐ Discharge Summary ☐ Consultations ☐ Entire Record ☐ Other records specify record types: _____ **C&S / Mental Health & Chemical Health: Dates of Service** _____ □ Diagnostic Assessment □ Treatment Plan □ Testing □ Discharge Summary □ Medication Management □ Social Work Services □ Verbal Communication □ Other, specify: _____ **Dental: Dates of Service** _____ ☐ X-Rays ☐ Office Notes ☐ Other records specify record types _____
Release Instructions (***How*** and ***When*** do you want the information?)	**Release Method / Format requested: (check one)** ☐ Paper/ Mail ☐ CD ☐ Fax **(IF OVER 30 PAGES NOTIFY IHB)** ☐ Verbal Disclosures ☐ Paper/ Patient Pick up (ID May be requested at the time of pick up) ☐ Two- Way Exchange of Information
Purpose of Release (***Why*** is it needed?)	☐ Continuing care /Treatment Planning ☐ Transfer of care ☐ Personal use or review * ☐ Litigation/legal * determination * Other*_____ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524
	I understand this release may include, but is not limited to, that which involves treatment or testing for alcohol/drug abuse, sickle cell anemia, sexually transmitted diseases, including HIV/AIDS, or mental health issues, that were maintained while a patient at your facility on any date, as well as any correspondences. This authorization will only include records prior to the date of signature.

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 Indian Health Board Notice of Privacy Practice describes how to cancel (revoke) this authorization.

The Indian Health Board will not restrict my treatment if I choose not to sign this authorization.

The Indian Health Board cannot prevent re-disclosure 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 The Indian Health Board from any and all liability resulting from a re-disclosure 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's Signature Date Relationship to patient/ Authority to act on behalf of patient

Patient/Legal Guardian's Printed Name _____ Revision 6/23/2016

Requested provider:_____ (For clinical use only)