

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

Patient Contact Information	NAME: _____ DATE OF BIRTH: _____ Phone Number: _____
Releasing Party: Clinic/Hospital/Health Care Provider, Person, or Organization <i>(Who has the information you want released?)</i>	NAME: _____ Address: _____ City: _____ State _____ Zip: _____ Phone Number: _____ Fax Number: _____
Receiving Party: Clinic/Hospital/Health Care Provider, Person, or Organization <i>(Who will the information be sent to?)</i>	NAME: _____ Address: _____ City: _____ State _____ Zip: _____ Phone Number: _____ Fax Number: _____
Information to be Released <i>(What do you want sent or released? Check the appropriate box.)</i> If requesting both medical and mental health records, you will need to fill out two separate releases.	Medical Dates of Service: _____ <input type="checkbox"/> Progress notes <input type="checkbox"/> Radiology/Diagnostic Test reports <input type="checkbox"/> Emergency record(s) <input type="checkbox"/> Obstetrics report <input type="checkbox"/> Operative Report <input type="checkbox"/> Lab report(s) <input type="checkbox"/> History & Physical exam <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Entire record <input type="checkbox"/> Other records specify: _____ C&S / Mental Health & Chemical Health/Psychiatry Dates of Service: _____ <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Testing <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Verbal Communication <input type="checkbox"/> Medication Management-Psychiatry <input type="checkbox"/> Social Work Services <input type="checkbox"/> Other, specify: _____ Dental: Dates of Service: _____ <input type="checkbox"/> X-Rays <input type="checkbox"/> Office Notes <input type="checkbox"/> Other records specify: _____
Release Instructions <i>(How and When do you want the information?)</i>	Release Method / Format requested: (check one) <input type="checkbox"/> Paper/ Mail <input type="checkbox"/> Fax (IF OVER 30 PAGES NOTIFY IHB) <input type="checkbox"/> Verbal Disclosures <input type="checkbox"/> CD <input type="checkbox"/> Paper/ Patient Pick up (ID May be requested at the time of pick up) <input type="checkbox"/> Two- Way Exchange of Information <input type="checkbox"/> Other: _____
Purpose of Release <i>(Why is it needed?)</i>	<input type="checkbox"/> Continuing care /Treatment Planning <input type="checkbox"/> Transfer of care <input type="checkbox"/> Personal use or review * <input type="checkbox"/> Litigation/legal/determination * + <input type="checkbox"/> Other * _____ <small>* Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 + Must be requested from legal representative</small>
<p>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.</p>	
<p>This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____</p> <ul style="list-style-type: none"> • 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, I 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

Requesting provider: _____ (For clinical use only)



Directions for Completion of Form

Please note: *IHB has up to 30 days to process your request.*

Patient Information: Individual whose information is being requested for and contact information for questions related to this release.

Releasing Party: Clinic/Hospital/Healthcare Provider: Identify who has the information you want release. **Please be as specific as possible.**

Examples: -Name of facility, location (Indian Health Board, MPLS)
-Provider/medical staff's name (Dr. Smith at MN Best Care Clinic)

Receiving Party: Clinic/Hospital/Health Care Provider, Person, or Organization

Please be as specific as possible.

Identify the Name, address, phone, fax and any other contact information of the individual who is *to receive* the information.

Information to Be Released: This section gives us the instructions for what information you want released.

-To disclose information pertaining on certain period/event- Identify the date range/year or procedure or diagnoses within the desired department.

Release Instructions: This tells us how you would like your information delivered.

-If you wish for us to fax this information, a working fax number along with a contact phone number is needed in the (Receiving Clinic) box.

-If you wish for us to mail this information, please make sure that the address you provide us (in the Receiving Clinic box) is current and accurate.

**If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section: "form on file for access by (person or relation) upon their specific request".

Purpose of Request: Please identify why you need a copy of your record.

-This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

-Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event.