Minnesota Standard Consent Form to Release Health Information

Complete Sections 1, 3 and 9. Sections 2, 6 & 8 are Optional

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 address (optional) _____
Medical Record/patient ID number (optional) _____

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:
First name _____ Last name _____
About how this form was completed. This person can be reached at:
Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____
Specific health care facility or location(s) (**YOUR CLINIC**)_____
Specific health care professional's name(s) (**YOUR MD**) _____

4 I am requesting that health information be sent to:

Organization(s) name **AUBURN COURTS HOME CARE**
And/or person: **ADMISSION RN**
Mailing address **501 N OAK STREET**
City **CHASKA**
Phone (optional) **952-361-0302** Fax (optional) **952-361-0411**
Information needed by (date) ___/___/_____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: 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	❑ Radiology report
❑ Emergency Room report	☒ Progress notes	❑ Radiology image(s)
❑ Surgical report	☒ Care plan	❑ Photographs, video, digital or other images
☒ Medications	☒ Immunizations	❑ Billing records
❑ Other information or instructions _____		

6 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 in 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 health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information:

☒ Patient's request	❑ Insurance application
☒ Review patient's current care	❑ Legal
☒ Treatment/continued care	❑ Appeal denial of Social Security Disability income or benefits
❑ Payment	❑ Marketing purposes (payment or compensation involved? ❑ NO ❑ YES, amount _____)
☒ Other (Please explain) **MOVE TO ASSISTED LIVING FACILITY**	

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.
I may stop this consent at any time by writing to the organization(s), facility(ies), and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.
I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may not longer be protected by federal or state privacy laws.
I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form.
If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end on year from the date the form is signed unless I indicate an earlier date or event here:
Date ___/___/_____ Or specific event: _____
MM DD YYYY

9 Patient's Signature _____ Date: ___/___/_____

MM DD YYYY

OR legally authorized representative's signature: _____ Date: ___/___/_____

MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____