CONSENT FORM TO RELEASE HEALTH INFORMATION

Complete the following seven steps:

STEP 1: *Patient Information*

First Name: _____ Last Name: _____

Date of Birth: _____ Previous Name(s): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Parent/Guardian Name: _____

STEP 2: *I am requesting health information to be **released from**:*

Organization Name: _____

And/or Person: First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone (optional): _____ Fax (optional): _____

STEP 3: *I am requesting that health information be **sent to**:*

Organization Name: _____

And/or Person: First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone (optional): _____ Fax (optional): _____

Information needed by (date): _____ (optional)

STEP 4: *Information to be released:*

IMPORTANT: Indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment: _____

☐ 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).

OR to only release specific portions of your health information, indicate the categories to be released:

☐ Allergy records (initial evaluation and progress notes)
☐ Allergy skin test reports
☐ Pulmonary function tests
☐ Radiology reports (x-ray/CT scan)
☐ Laboratory reports
☐ Progress/Clinic notes
☐ Immunotherapy (allergy shot) extract prescriptions
☐ Immunotherapy schedule/shot record
☐ Other information or instructions: _____

STEP 5: *Reason for releasing information:*

☐ Patient's request
☐ Transfer/Continued care
☐ Other (please explain): _____

STEP 6: *I understand that sensitive information (STD, HIV/AIDS, drug/alcohol abuse or treatment, and mental health information) can be released unless specifically noted. I also understand that once personal health information (PHI) is disclosed to others, it may be re-disclosed to individuals or organizations not subject to HIPAA and therefore may no longer be protected by HIPAA.*
I understand that my records are protected under the federal confidentiality regulations as well as the State of Minnesota regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that without an expressed revocation, it will expire 1 year from the date of my signature.

_____ _____

Patient signature or Parent/Guardian signature *Date*

STEP 7: SUBMIT THIS FORM TO THE ORGANIZATION NAMED IN STEP 2