MINNEAPOLIS SCHOOL BASED CLINICS program

Authorization for Request/Release of Protected Health Information

Source Individual

A program of the Minneapolis Department of Health & Family Support, City of Lakes

Source Individual Information

Last Name	First Name	
Street Address		
City	State	Zip

Authorized Parties *check appropriate boxes*

Minneapolis Dept. of Health & Family Support
250 South 4th Street, Room 510
Minneapolis, MN 55415

Attn:_____

TO: ❑ **FROM:** ❑

Hospital/Doctor:_____

Address:_____

_____

Telephone:_____

TO: ❑ **FROM:** ❑

Information to be Released *initial next to each that apply*

Date of Service:

____ Most recent history and physical	____ Lab reports	____ Mental health information
____ Immunization record	____ STI testing	____ HIV testing
____ Pap/Colposcopy results	____ Medications	____ Alcohol & drug abuse records
____ Discharge summary: date:_____	____ Progress/Clinic notes	____ Other:_____

Authorization *I understand authority to disclose my health information is voluntary and I may refuse to sign.*

- This authorization shall remain in effect for one year from the date of patient's signature, or the period of time as specified here:_____.
- This authorization may be stopped by written request at any time to the address listed for the Minneapolis Department of Health & Family Support. A revocation will not apply to information that has already been released in response to this authorization.
- Once information is released pursuant to this authorization, the information may be subject to re-disclosure and no longer protected by the federal privacy rule, 45 CFR Parts 160 and 164.
- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and /or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____.
  Please indicate any restrictions: (specify) _____
- This authorization must be filled out completely and signed and dated in order to be considered valid.
- A copy of this authorization will be considered as valid as the original authorization.
- Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon the signing of this authorization form.

Signature

Signature of Source Individual	Date
Signature of Source Parent or Guardian *if source is under 18 years old*	Date

Staff Use Only
Information released by:_____Date: _____