MINNEAPOLIS SCHOOL BASED CLINICS program

Authorization for Request/Release of Protected Health Information

Edison School Based Clinic

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

Patient Information

Last Name	First Name		
Street Address			
City		State	Zip
Birth Date (mm/dd/yyyy)	Social Security or Student ID #		

Authorized Parties *check appropriate boxes*

Edison High School Based Clinic 700 22nd Ave NE, Room 107 Minneapolis, MN 55418 (p) 612-668-1321 (f) 612-668-1391 **TO:** ❑ **FROM:** ❑	**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 *check all that apply*

_____ Complete medical records
_____ Most recent history and physical
_____ Immunization record
_____ Pap/Colposcopy results
_____ Discharge summary – Date:_____

Lab reports
_____ Chlamydia
_____ Gonorrhea
_____ Wet Mount/Prep
_____ Urinalysis

_____ Mental Health Information
_____ Urine Cultures
_____ Blood Work, (specify) _____
_____ Other:_____

Purpose of Information Request/Release

_____ Continuing Health Care

_____ Other:_____

Authorization

- 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 revoked by written request of the patient at any time to the address listed for the Edison High School Based Clinic. 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 Patient/Authorized Person	Authorized Person's authority to sign	Date
Reason Patient is unable to sign (if applicable)		