



## Authorization for Request/Release of Protected Health Information Henry School Based Clinic



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

Authorized Parties <i>check appropriate boxes</i>		
<b>Henry High School Based Clinic</b> 2020 43 <sup>rd</sup> Ave N, Room 212 Minneapolis, MN 55412 (p) 612-668-1944 (f) 612-668-2011  TO: <input type="checkbox"/> FROM: <input type="checkbox"/>	<b>Minneapolis Dept. of Health &amp; Family Support</b> 250 South 4 <sup>th</sup> Street, Room 510 Minneapolis, MN 55415  Attn: _____  TO: <input type="checkbox"/> FROM: <input type="checkbox"/>	<b>Hospital/Doctor:</b> _____ Address: _____ _____ Telephone: _____  TO: <input type="checkbox"/> FROM: <input type="checkbox"/>

Information to be Released <i>initial next to each that apply</i>		
Date of Service: _____		
<input type="checkbox"/> Most recent history and physical	<input type="checkbox"/> Lab reports	<input type="checkbox"/> Mental health information
<input type="checkbox"/> Immunization record	<input type="checkbox"/> STI testing	<input type="checkbox"/> HIV testing
<input type="checkbox"/> Pap/Colposcopy results	<input type="checkbox"/> Medications	<input type="checkbox"/> Alcohol & drug abuse records
<input type="checkbox"/> Discharge summary: date: _____	<input type="checkbox"/> Progress/Clinic notes	<input type="checkbox"/> Other: _____

Purpose of Information Request/Release
<input type="checkbox"/> Continuing Health Care  <input type="checkbox"/> Other: _____

Authorization <i>I understand authority to disclose my health information is voluntary and I may refuse to sign.</i>
<ul style="list-style-type: none"> <li>This authorization shall remain in effect for one year from the date of patient's signature, or the period of time as specified here: _____.</li> <li>This authorization may be stopped by written request at any time to the address listed for the Henry High School Based Clinic. A revocation will not apply to information that has already been released in response to this authorization.</li> <li>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.</li> <li>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: <input type="checkbox"/>. Please indicate any restrictions: (specify) _____</li> <li>This authorization must be filled out completely and signed and dated in order to be considered valid.</li> <li>A copy of this authorization will be considered as valid as the original authorization.</li> <li>Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon the signing of this authorization form.</li> </ul>

Signature		
Signature of Patient/Authorized Person	Authorized Person's authority to sign	Date
Reason Patient is unable to sign (if applicable)		

Staff Use Only
Information released by: _____ Date: _____