MINNEAPOLIS SCHOOL BASED CLINICS program

Authorization for Request/Release of Protected Health Information

South School Based Clinic

a program of the Minneapolis Health Department, Minneapolis 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*

South High School Based Clinic	**Minneapolis Health Department**	**Hospital/Doctor:**_____
3131 19th Avenue S, Room 122 Minneapolis, MN 55407 (p) 612-668-4333 (f) 612-668-4405	250 South 4th Street, Room 510 Minneapolis, MN 55415 Attn:_____	Address:_____ _____ Telephone:_____
TO: ☐ **FROM:** ☐	**TO:** ☐ **FROM:** ☐	**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:_____

Purpose of Information Request/Release

____ Continuing Health Care

____ 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 South 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)		

Staff Use Only

Information released by:_____Date: _____