



Authorization for Request/Release of Protected Health Information Southwest 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>		
Southwest High School Based Clinic 3434 W 47 th Street, Room E021 Minneapolis, MN 55410 (p) 612-668-3040 (f) 612-668-3078 TO: <input type="checkbox"/> FROM: <input type="checkbox"/>	Minneapolis Health Department 250 South 4 th Street, Room 510 Minneapolis, MN 55415 Attn: _____ TO: <input type="checkbox"/> FROM: <input type="checkbox"/>	Hospital/Doctor: _____ 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"> 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 Southwest 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: <input type="checkbox"/>. 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: _____