UNIVERSITY OF MINNESOTA
Community-University Health Care Center 2001 Bloomington Ave Phone: 612-301-3433
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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

My Information should be released FROM:

☐ Community-University Health Care Center

☐ Name:

_____

Address: _____

City:_____ State:____ Zip:_____

Phone:_____ Fax:_____

My Information should be released TO:

☐ Community-University Health Care Center

☐ Name: _____

Address: _____

City:_____ State:____ Zip:_____

Phone:_____ Fax:_____

Patient Identifying Information: LABEL

Name (Please print): _____

Date of Birth: _____

Medical Record No: _____

Address: _____

City:_____ State:_____ Zip:_____

How to Release (Please Check One):

☐ Mail the information to the address written above.

☐ Fax the information to the fax number written above.

☐ I or _____ (valid photo ID required)

will pick up the records on _____

*Allow one week unless other arrangements are made.

I authorize the release of:

☐ Printed copy of my records.

☐ Electronic copy of my records.

☐ Written exchange of information between parties.

☐ Verbal communication between parties.

☐ Other (explain) : _____

Requesting records for: ☐ Last 6 months ☐ Last 1 Year

☐All ☐From_____ to _____

The purpose of this release is: ☐ At the request of the individual. ☐ Treatment/continued care.

☐ Education/research. ☐Case management/care coordination. ☐ Other:_____

Released records should include: ☐ All records (except films or slides) or check all that apply below:

☐ Medical clinic records. ☐ X-ray typed reports. ☐Therapy notes.

☐ Laboratory/Pathology records. ☐ Psychiatric diagnostic assessment. ☐ Psychiatry notes.

☐Immunizations. ☐Case management information. ☐Dental notes.

☐ X-ray films/slides/CDs. ☐ HIV/AIDS testing. ☐ Other:_____

These records require specific consent for release. Must be separate ROI's for:

☐ Psychotherapy notes. *This consent may not be combined with any other consent on the same form.*

☐ Part 2 Counseling notes. *This consent may not be combined with any other consent on the same form.*

☐ Couples/Family Therapy. *Each party must complete a separate consent.*

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I understand that once information is released pursuant to this authorization, CUHCC cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information to other health care providers. There is no charge for release of information to other health care facilities for continuing care.
- I understand that my treatment will not be conditioned on my signing this authorization except for research-related treatment.
- I understand that I am entitled to a copy of this *Authorization for the Release of Health Information*.
- This authorization will expire one year from the date of my signature unless I indicate an earlier date here: _____

_____ _____ _____

Signature of Patient/Authorized Person | Authorized Person's authority to sign | Date

_____ REASON PATIENT IS UNABLE TO SIGN: □ Minor □Deceased □Other

Print Name of Authorized Person