UNIVERSITY OF MINNESOTA
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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:
☐ All
☐ Last 6 months
☐ Last 1 Year
☐ 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.*
☐ Couples/Family Therapy. *Each party must complete a separate form.*
* Chemical dependency. *Will not include SUD records covered by 42 CFR Part 2. (See SUD ROI)*

- 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
Printed name of Authorized Person

FOR USE OF CUHCC STAFF ONLY

☐ Information was provided to the individual as requested.
☐ Verbal information: file form in medical record.
☐ Form was faxed to request information on: _____
Received by:_____Date: _____