Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name_____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____ State_____ Zip code _____

Daytime phone _____ E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____ Last name_____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

___ Specific dates/years of treatment _____

___ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

___ History/Physical	___ Mental health	___ HIV/AIDS testing
___ Laboratory report	___ Discharge summary	___ Radiology report
___ Emergency room report	___ Progress notes	___ Radiology image(s)
___ Surgical report	___ Care plan	___ Photographs, video, digital or other images
___ Medications	___ Immunizations	___ Billing records

___ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

___ Chemical dependency program *(see definition in instructions)*

___ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

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Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

___ Patient's request
___ Review patient's current care
___ Treatment/continued care
___ Payment
___ Insurance application
___ Legal
___ Appeal denial of Social Security Disability income or benefits
___ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____)
___ Other (please explain) _____

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I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

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Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

Or legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

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