Minnesota Lung Center / Minnesota Sleep Institute
4570 West 77th Street, Suite 150
Phone # 952-567-7400 Edina, MN 55435 Fax #: 952-567-7414

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____
(Patient's First Name) (Middle) (Last) (Date of Birth)

_____
(Client/Patient Address) ***<u>ALL PORTIONS MUST BE COMPLETED FULLY BY PATIENT</u>***

FROM: Physician/Clinc/Hospital _____
ADDRESS:_____
CITY/STATE/ZIP: _____
PHONE: _____ FAX: _____

TO: Requestor/Physician/Clinic/Hospital/Self _____
ADDRESS:_____
CITY/STATE/ZIP: _____
PHONE: _____ FAX: _____

The information is released for the purpose of: _____

PLEASE INDICATE THE INFORMATION TO BE RELEASED OR DISCLOSED:

___ Any and all medical records (including chemical dependency/drug or alcohol abuse treatment records)
___ Most recent 5-year medical history (including chemical dependency/drug or alcohol abuse treatment)
___ Pathology Report
___ Radiology Report and Films
___ Laboratory Reports
___ Other (Explain or describe as instructed) _____

DATES OF SERVICE: FROM _____ TO _____

<u>All records pertaining to psychiatric/mental health and/or HIV related illnesses will be released unless indicated below:</u>
INITIAL (_____) DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV.

_____

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

<u>I ALSO UNDERSTAND THAT THERE MAY BE A CHARGE BY THE CLINIC AND/OR SERVICE PROVIDER FOR COPIES OF MEDICAL RECORDS, PER MINNESOTA STATUTES, SECTION 144.292 SUBDIVISION 6.</u>**

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been in reliance upon this authorization (example: probation, parole, etc.). Unless revoked earlier, this authorization will expire one year from the date of signing or until (insert applicable date) _____.

I have a right to receive a copy of this authorization. A photo/fax/scanned/or email copy of this authorization will be treated in the same manner as an original.

_____

(Signature of person releasing information (Patient/Guardian) (Date signed)

_____

(Signature of Authorized Legal Representative) (If you are the legal responsible party acting on behalf of this patient, please provide legal documentation.)