



**HealthPartners**  
*Release of Information Services*  
 5100 Gamble Drive, Suite 100  
 St. Louis Park, MN 55416-1582

**Patient Authorization for Release  
 of Protected Information**

Patient Name: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

**I authorize the disclosure and use of health information as described below:**

**1. Who may disclose (give out) this information:**

Name of facility and/or provider \_\_\_\_\_

**2. Who may receive and use this information:**

(Please print name, address and phone number.)

\_\_\_\_\_

Relative  Legal representative  Another provider  Employer  
 Relationship: \_\_\_\_\_  Attorney  Guardian  Other \_\_\_\_\_

**3. The purpose for which this information may be disclosed:**

For treatment  For care coordination  Payment  At the request of the individual listed above  
 Other \_\_\_\_\_

**4. What information may be disclosed:**

Entire Medical Record (includes all listed below)  Appointment Information  Medical Advice  
 Behavioral (Mental) Health Records  Entire Dental Record  Eye/Optical Records  
 Most recent physical & history  Chemical Health Records  Most recent discharge summary  
 Medication Information  Allergy list  Immunization record  
 X-ray and/or imaging results from \_\_\_\_\_ to \_\_\_\_\_  
 Consultation reports from (please supply doctor's name) \_\_\_\_\_  
 Other (as described here) \_\_\_\_\_

**5. This authorization expires (ends) on the following date, event or condition:**

Note: If date, event or condition is not specified, this authorization expires twelve (12) months from the date I sign this form.

**I understand that:**

• I may revoke this authorization at any time by notifying, in writing, the facility listed above.

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