Patient Authorization for Release of Protected Health Information

Instructions:

Make sure **ALL** blanks on this form are **printed** and **complete** or we cannot process this request. **Please fill in complete address.** ***Additional copies of this form are available at the front desk to release information to/from additional providers*

Patient name: _____
First MI Last

Address: _____
City State Zip

Patient phone: (_____)_____ Patient date of birth:_____/_____/_____

I, _____, authorize NorthStar Regional to:

☐Disclose Confidential Information to: Name:_____

☐Obtain confidential information from: Address: _____

☐Exchange confidential information with: Phone (required): (_____)_____

The purpose for which this information may be disclosed:

☐Treatment ☐Patient Access ☐Insurance ☐Social Security Appeal

☐Care Coordination ☐Litigation ☐Other:_____

What information may be disclosed:

☐Diagnostic Assessment ☐Billing Information ☐Appointment Information

☐Treatment Plan ☐Discharge Summary ☐Verbal Consultation-Exchange

☐All Progress Notes ☐Only Last 3 Progress Notes ☐Psychological Testing Results (specify):

☐Other:_____ _____

_____ **I agree that my HIV status and/or drug/alcohol usage may be disclosed.**
Initials

_____ Please send all current records

Dates Requested Information from: _____/_____/_____ to _____/_____/_____
MM / DD / YYYY MM / DD / YYYY

This Authorization expires (ends) on the following date, event or condition:_____
(If a 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. Revoking this authorization does not apply to information that has already been released under this authorization. I have the right to inspect or copy the health information to be disclosed. Information that goes to a health care provider or health plan covered by federal privacy laws will be protected by federal privacy laws. NorthStar Regional cannot re-disclose any information from other persons or entities as protected by state or federal privacy laws. I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating information for a third party, such as insurance companies. **A fee may be charged for retrieval and copying of records according to MN 144.335 and Federal Rule 164.521.**

Patient Signature: _____ Date: _____/_____/_____

Parent, guardian, personal representative (if applicable):

Signature: _____ Date: _____/_____/_____

Witness (if client is unable to sign):

Signature: _____ Date: _____/_____/_____