NORTH MEMORIAL HEALTH

MAPLE GROVE HOSPITAL

9875 Hospital Drive
Maple Grove, MN 55369

AUTHORIZATION FOR RELEASE OF INFORMATION

MR #_____

Patient:_____

BirthDate:_____

Phone Number:_____

This will authorize: ☐North Memorial Health Hospital ☐Maple Grove Hospital ☐Other_____

☐North Memorial Health **Clinic Name**:_____

To release information to _____
(Patient Designee)

_____
(Address) (City) (State) (Zip)

Send to Email Address:_____

Information to be released includes records from the following dates:_____

Information to be released:

_____ Cardiac Test Results
_____ Consultation Reports
_____ Discharge Summary
_____ EKG Reports
_____ Emergency Department Reports
_____ History & Physical Examination
_____ Laboratory Reports: _____
_____ Nurses Notes
_____ Operative Reports
_____ Pathology Reports
_____ Physician Orders
_____ Physician Progress Notes
_____ Radiology Films
_____ Radiology Reports
_____ Detailed Billing
_____ Other (specify):_____

Reports released may include information about mental status/drug/alcohol and HIV testing results.
If there is specific information that you do not want released, please write here:

_____

The information is needed for the following purpose: _____

Information to be released via: ☐ Mail ☐ Pick-up ☐ FAX ☐ Courier ☐ Review Only
☐ Encrypted Email ☐ DVD (☐ mail ☐ pickup) ☐ MyChart
☐ Released by Care Unit ☐ Other _____

I designate above designee to access my medical records for length of time. Start Date: _____
End Date:_____

This authorization will expire upon the earliest of the following dates: 1) the date the stated purpose is fulfilled 2) the date I write here _____3) the date that I revoke this authorization. If not otherwise stated, this will expire one year from the date signed. I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that North Memorial Health and Maple Grove Hospital has relied on the authorization. A photocopy or facsimile of this authorization shall be treated as valid as the original. I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

_____ Date: _____
Signature of Patient or Patient's Representative Must be filled in

(If Patient's Representative, under what legal authority are you signing?)

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Other (specify): _____

Not required to sign this authorization in order to receive treatment.

Original: Facility Copy: Patient F450 04/17