NORTH
MEMORIAL HEALTH
3300 Oakdale Ave. N
Robbinsdale, MN 55422

Authorization for Release of Information

MAPLE GROVE HOSPITAL
9875 Hospital Drive
Maple Grove, MN 55369

CUSTOMER INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Provider (*WHO* has the information you want to be released?) Please list specific hospital and/or clinic location.	NAME: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Receiving Party (*WHERE* do you want the information sent? *WHO* may have the information?)	NAME: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____State: _____ Zip: _____ Fax Number (Only for urgent customer care requests)_____
Information to be Released (*WHAT* do you want sent or released? Check all appropriate items that apply.)	Information to be released includes records from the following dates: _____ ____ Cardiac Test Results ____ History & Physical ____ Physician Progress Notes ____ Consultation Reports ____ Laboratory Reports ____ Radiology Films ____ Discharge Summary ____ Nurses Notes ____ Radiology Reports ____ EKG Reports ____ Operative Reports ____ Billing Records ____ Emergency Reports ____ Pathology Reports ____ Other (specify): _____ Reports released may include sensitive information such as mental status/chemical dependency, HIV/STD or pregnancy testing results. If there is specific information that you do not want released, please write here:
Purpose of Release (*WHY* is it needed?)	The information is needed for the following purpose: _____
Release Instructions (*HOW* and *WHEN* do you want the information?)	Date information is needed: _____ (Please allow adequate time for processing) ☐ Mail ☐ Pick-up ☐ MyChart ☐ Courier ☐ Review Only ☐ FAX ☐ DVD (☐ mail ☐ pickup) ☐ Released by Care Unit ☐ Other ☐ Encrypted Email (address) _____

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 Customer or Customer's Representative — Must be filled in

If Customer'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

Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524