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

Authorization for Release of Information

HIM Phone: (763) 581-4467, HIM Fax: (763) 581-4447
Email: MedicalRecords@NorthMemorial.com

PATIENT 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 patient 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 ☐ MyChart ☐ Courier ☐ Review only ☐ FAX ☐ DVD (☐ mail) ☐ Encrypted Email (address) ☐ Unencrypted Email (address)______ Note: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and there's a potential risk it could be intercepted and viewed by a third party. North Memorial Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.

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 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

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