Gillette Children's Specialty Healthcare

AUTHORIZATION TO RELEASE INFORMATION

Health Information Services
mailstop-205020
200 University Ave. E.
St. Paul, MN 55101
Phone: 651-312-3122
Fax: 651-229-3888
ROI@gillettechildrens.com

1. You must clearly complete all items in this document marked with an asterisk (*). See back of form for more information.

Medical Record Number (Gillette use only):_____

* Patient Name: _____ *Patient Date of Birth: _____

***2. Check all that apply:**

☐ I authorize Gillette to release my documents to the person or organization below.
☐ I authorize Gillette to communicate verbally with the person or organization below.
☐ I authorize the person or organization below to release copies of my documents to Gillette.

***3. Complete this section to authorize the release of information to/from this person or organization.**

*Contact:_____

*Facility:_____

*Address:_____

*City: _____ *State: _____ *Zip Code:_____

*Phone:_____ FAX (if known): _____

4. Dates of service to be released _____ (if left blank, we will release one year's worth of recent records.)

***5. What information can we release? Check the items that apply in 5a and/or 5b.**

***5a.** I authorize the release of the items checked.

☐ Discharge Summary
☐ Operative Report(s)
☐ History & Physical Exam
☐ Outpatient Clinic Notes
☐ Radiology Reports (X-ray, CT, MRI, etc. **reports ONLY**, does **not** include images)
☐ Laboratory Report(s)
☐ Pathology Report(s)
☐ Consultation Report(s)
☐ Special Testing

Rehabilitation Report(s); specify which ones:
☐ **PT** ☐ **OT** ☐ **Speech Therapy**
☐ School/Academics/IEP
☐ Therapeutic Recreation
☐ Discharge Instructions
☐ Growth Charts
☐ Media (photos, videos, and other diagnostic images)
☐ Radiology Image(s) – (such as X-rays, CTs, MRIs, and ultrasounds)
☐ Genetic Testing
☐ Other: _____

***5b. *** We **cannot** release the following information unless the patient or his/her legal guardian "**INITIALS**" the line next to it.

_____ Psychiatric _____Social Work _____Chemical Dependency
_____ Psychology _____ Neuropsychology _____ AIDS/HIV

6. I am asking to release information for this purpose:

☐ Continuing Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Education
☐ Other, specify: _____

I understand that:

- I may revoke this authorization at any time by **WRITTEN REQUEST**.
- Revoking my authorization will **NOT** apply to information already released in response to this authorization.
- A photocopy or facsimile of this authorization will be treated in the same manner as if it were the original form.
- Once information is released because of this authorization, Gillette cannot prevent re-disclosure of the information by a third party.
- Gillette may not make treatment, payment, enrollment or eligibility for benefits a condition of my signing this form.
- **This authorization expires one year from the date I sign it.**

***7. Check ONLY ONE.**

____I authorize the release of information gathered up to the date I signed this form.

____I authorize the release of information gathered up to the date and for one year after the date I signed this form, or until date or event specified here: Date _____or Event_____

(no more than one year from date of signature)

8. Please sign here

_____ _____ _____

*Patient/Parent of minor/Legal Responsible party *Relationship *Date

Driver's license or ID required when picking up records. **Proof of Guardianship/Durable POA/court order may be required (see back note)**

(Office Use Only)

A copy of this form must be included with the materials requested

Date Received: _____ Date Processed: _____ Request Completed by: _____

8083-003
12/04, ….. 4/16, 11/16, 2/18

Directions for Completing This Form

(Patient reference only)

NOTE: This form applies only to the patient whose name and date of birth appears in Item 1 on Page 1. If you are not the patient or parent of the minor patient, you must provide legal guardianship papers, Durable Power of Attorney papers, or court orders (or have them on file at Gillette) before we can process this request. This is in accordance with MN statue 144.293.

You must tell Gillette, in writing, if you want to revoke your authorization (that is, if you want to stop any future release of information that you previously allowed by filling out this form).

Be sure to complete all sections of the form that are marked with an asterisk (*). ***An incomplete form will delay processing!***

1. Write the patient's name and date of birth clearly and legibly. Gillette staff will add the patient's medical record number when the authorization is received.
2. Tell us if you want Gillette to release, receive documents, and/or only exchange information verbally.
3. Give us the name and other requested information for the person or organization to whom you are allowing information released to or from.
4. Tell us dates for which you want information release. (For example, you might allow us to release information from 2008 to the present or for 2/10/2010 date of service only)
5. Check any and all boxes to show us what information you are allowing us to release.
   5a. If you want us to release **any** of the information in the 5a box **you must** check the boxes next to those items you want us to release.
   5b. If you want us to release anything in the 5b box (Psychiatric, Chemical Dependency, Social Work, Psychology, Neuropsychology Evaluation or Aids/HIV information), **you must initial** the line next to those items.
6. (Optional)--To help us identify and track your request, mark the box that best describes why you are allowing the information to be released.
7. Check the statement that best describes what you want us to do:
   -If you only want past information (information up to and including the date you sign the form), check the first statement.
   -If you want information for up to one year after you sign the form, check the second statement.
   -If you want information only up until a particular date or event, check the second statement and fill in the date or event when you want us to stop releasing information. (no more than one year from date of signature)
8. You must sign and date the form.

Direct your questions to:
Gillette Children's Specialty Healthcare
Release of Information-mail code 205020
200 University Ave. E.
St. Paul MN 55101
Phone 651-312-3122
Fax 651-229-3888

Patient/Parent of Minor/Guardian may use this space below to track any authorizations they have signed along with the expiration date(s).

_____ **Expires:**_____

_____ **Expires:** _____

_____ **Expires:** _____

_____ **Expires:** _____

_____ **Expires:** _____