

1. Patient Information	NAME _____ Office Use Only MRN _____ Date of Birth _____ Day phone _____ Email _____				
2. Health Care Provider or Clinic or Hospital who has the information you want released?	NAME/ORGANIZATION _____ Phone _____ Address _____ Fax _____ City _____ State _____ Zip _____				
3. Where do you want the information to be sent?	NAME/ORGANIZATION _____ Attention _____ Address _____ Phone _____ City _____ State _____ Zip _____ Fax Number _____				
4. Why is it needed?	<input type="checkbox"/> Continuing care <input type="checkbox"/> Workers' Compensation* <input type="checkbox"/> School <input type="checkbox"/> Personal use* <input type="checkbox"/> Insurance application* <input type="checkbox"/> Insurance payment/claim* <input type="checkbox"/> Legal* <input type="checkbox"/> Other _____				
5. What are the approximate dates of information you want released? What do you want released? Choose Routine for items a health care provider typically needs, or select individual records.	Service Dates Between _____ to _____ Send All Routine Records <input type="checkbox"/> Notes, History and Physical, Discharge Summary, Emergency Room, Lab, Radiology, Procedures, Test Results and Consultations Or Send Other Records <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Diagnostic Test Results <input type="checkbox"/> Consultations <input type="checkbox"/> Radiology Reports <input type="checkbox"/> History and Physical Exams <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Operative/Procedure Reports <input type="checkbox"/> Progress/Provider Notes <input type="checkbox"/> HIV/Aids Testing <input type="checkbox"/> Emergency Reports <input type="checkbox"/> Rehab Reports (PT/OT/SP) <input type="checkbox"/> Chemical Dependency/Substance Abuse Reports <input type="checkbox"/> Form Completion <input type="checkbox"/> Medication List <input type="checkbox"/> Other (specify content and dates) _____ <input type="checkbox"/> Radiology Films/MRI <input type="checkbox"/> Billing Records <input type="checkbox"/> Pathology Slides (are sent directly to the facility listed in step 3) <hr/> All information regarding alcohol and/or drug abuse or behavioral health will be released unless you restrict by <u>initialing</u> : _____ Do not release alcohol and/or drug abuse information _____ Do not release behavioral health information				
6. When is it needed?	Date the information is needed? ____/____/____ Or Date of the appointment? ____/____/____ To check on the status of your copies, please email ehstatus@cioxhealth.com or call 866-203-7454.				
7. How do you want the information?	Release Method / Format requested: For copies: <input type="checkbox"/> MyChart or <input type="checkbox"/> Paper or <input type="checkbox"/> CD/DVD or <input type="checkbox"/> Fax <input type="checkbox"/> Pick up (Photo ID is required at pickup time) <input type="checkbox"/> Verbal (no copies) For Films/MRI: <input type="checkbox"/> CD/DVD				
<ul style="list-style-type: none"> • This authorization lasts for one year after the date you sign it unless you enter a different expiration date here: _____ • I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it. • I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. • I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. • I understand that Essentia Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. • I understand, upon request, I will receive a copy of this form after I have signed it. • I understand that in compliance with MN Statute 144.293, WI Administrative Code HHS117, NDCC 23-12-14, Federal Rule 45 CFR 164.524; Charges may apply in ID. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.* • I understand a photocopy or fax of this form is the same as the original. 					
8. Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation .	<table border="0"> <tr> <td data-bbox="293 1472 902 1577"> _____ <i>Patient Signature</i> </td> <td data-bbox="902 1472 1570 1577"> _____ <i>Signature of Authorized Person</i> <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-appointed guardian/conservator <i>Include legal documentation</i> </td> </tr> <tr> <td data-bbox="293 1577 902 1631"> _____ <i>Date</i> </td> <td data-bbox="902 1577 1570 1631"> _____ <i>Date</i> </td> </tr> </table>	_____ <i>Patient Signature</i>	_____ <i>Signature of Authorized Person</i> <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-appointed guardian/conservator <i>Include legal documentation</i>	_____ <i>Date</i>	_____ <i>Date</i>
_____ <i>Patient Signature</i>	_____ <i>Signature of Authorized Person</i> <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-appointed guardian/conservator <i>Include legal documentation</i>				
_____ <i>Date</i>	_____ <i>Date</i>				

Email: ReleaseOfInformation@EssentiaHealth.org

Mail to: Essentia Health – HIM
502 East Second Street
Duluth MN 55805

Telephone Number: 866-203-7454

Fax Number: 920-593-3114
(Use this fax number to submit only Authorization Forms.)



AUT001

Authorization For Use and Disclosure of Protected Health Information

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