

Authorization for Northfield Hospital + Clinics to Release Health Information

1.	Patient's Name: _____ Previous Name(s): _____ Address: _____ City: _____ State: _____ Zip: _____ Daytime Phone: _____ Email (optional): _____ Patient Date of Birth: _____ Medical Record/Patient ID Number (optional): _____																	
2. Release Information From: <small>(check all that apply) *Addresses on the back*</small>	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Farmington Clinic</td> <td><input type="checkbox"/> ENT Clinic - Faribault</td> <td><input type="checkbox"/> Orthopedic Services</td> <td><input type="checkbox"/> Northfield Hospital (includes EMS)</td> </tr> <tr> <td><input type="checkbox"/> Lakeville Clinic</td> <td><input type="checkbox"/> Express Care Clinic</td> <td><input type="checkbox"/> Rehabilitation Services</td> <td><input type="checkbox"/> Diagnostic Imaging</td> </tr> <tr> <td><input type="checkbox"/> Lonsdale Clinic</td> <td><input type="checkbox"/> Cancer Care & Infusion Center</td> <td><input type="checkbox"/> Women's Health Center</td> <td><input type="checkbox"/> Long Term Care Center</td> </tr> <tr> <td><input type="checkbox"/> Northfield Clinic</td> <td><input type="checkbox"/> Northfield Eye Physicians & Surgeons</td> <td><input type="checkbox"/> Home Care & Hospice</td> <td style="text-align: right;">Addresses on the back</td> </tr> </table>	<input type="checkbox"/> Farmington Clinic	<input type="checkbox"/> ENT Clinic - Faribault	<input type="checkbox"/> Orthopedic Services	<input type="checkbox"/> Northfield Hospital (includes EMS)	<input type="checkbox"/> Lakeville Clinic	<input type="checkbox"/> Express Care Clinic	<input type="checkbox"/> Rehabilitation Services	<input type="checkbox"/> Diagnostic Imaging	<input type="checkbox"/> Lonsdale Clinic	<input type="checkbox"/> Cancer Care & Infusion Center	<input type="checkbox"/> Women's Health Center	<input type="checkbox"/> Long Term Care Center	<input type="checkbox"/> Northfield Clinic	<input type="checkbox"/> Northfield Eye Physicians & Surgeons	<input type="checkbox"/> Home Care & Hospice	Addresses on the back	
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3. Release Information To: <small>(allow 7-10 days to process this release)</small>	Organization Name: _____ and/or Person Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone (optional): _____ Fax (optional): _____ Email: _____																	
4. Health Information to be Released:	<input type="checkbox"/> Pertinent Record Set (Two years of records will be sent) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Discharge Summaries</td> <td><input type="checkbox"/> E.K.G. Reports</td> <td><input type="checkbox"/> Mammogram Images</td> </tr> <tr> <td><input type="checkbox"/> Operative Reports</td> <td><input type="checkbox"/> Billing Records</td> <td><input type="checkbox"/> Consultation Reports</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Outpatient Reports</td> <td><input type="checkbox"/> Immunization Reports</td> </tr> <tr> <td><input type="checkbox"/> History and Physical</td> <td><input type="checkbox"/> Radiology Images</td> <td><input type="checkbox"/> Office Visit Notes</td> </tr> <tr> <td><input type="checkbox"/> Lab Data, including:</td> <td><input type="checkbox"/> Radiology Reports</td> <td><input type="checkbox"/> Other, including: _____</td> </tr> </table> Dates Requested: From: _____ To: _____ (specific date/date range required) The following information requires special consent by law. Even if you indicate all health care information, you must specifically request the following information in order for it to be released: <table style="width: 100%; border: none; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Chemical Dependency Program</td> </tr> <tr> <td><input type="checkbox"/> Psychotherapy Notes</td> </tr> </table>	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> E.K.G. Reports	<input type="checkbox"/> Mammogram Images	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Outpatient Reports	<input type="checkbox"/> Immunization Reports	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Lab Data, including:	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other, including: _____	<input type="checkbox"/> Chemical Dependency Program	<input type="checkbox"/> Psychotherapy Notes
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5. Written and Oral Information:	By indicating any of the categories in Section 4, you are giving permission for written information to be released and for a person in Section 2 to talk to a person from Section 3 about your health information. If you do not want to give your permission for a person in Section 2 to talk to a person from Section 3 about your health information, indicate that here (check mark or initials): _____																	
6. Reason(s) for Release:	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Transfer of care</td> <td><input type="checkbox"/> Treatment/continued care</td> <td><input type="checkbox"/> Insurance</td> </tr> <tr> <td><input type="checkbox"/> Personal use</td> <td><input type="checkbox"/> Legal</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Review patient's current care</td> <td><input type="checkbox"/> Disability determination</td> <td></td> </tr> </table>	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Treatment/continued care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal use	<input type="checkbox"/> Legal	<input type="checkbox"/> Other:	<input type="checkbox"/> Review patient's current care	<input type="checkbox"/> Disability determination									
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7. Authorization:	<p>I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in Section 3.</p> <p>This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital", or "once the health information is sent".</p> <p>I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in Section 2.</p> <p>If the organization, facility or professional named in Section 2 has already released health information based on my consent, my request to stop will not work for that health information.</p> <p>I understand that when the health information specified in Section 4 is sent to the third party named in Section 3, the information could be redisclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.</p> <p>I understand that if the organization named in Section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.</p> <p>If I choose not to sign this form and the organization named in Section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.</p> <p>I understand that this release will take effect on the date signed and will be in effect for one year.</p>																	
_____ Signature of Patient or Authorized Representative	_____ Date of Signature																	
 R O I _____ Printed Name of Patient or Authorized Representative	_____ If other than patient, state relationship and authority to sign																	

Release of Information List:

Farmington Clinic
4645 Knutsen Drive
Farmington MN 55024
Tel: 651-460-2300
Fax: 651-460-2301

Lakeville Clinic/Urgent Care
9974 214th Street
Lakeville MN 55044
Tel: 952-469-0500
Fax: 952-469-0505

Lonsdale Clinic
103 15th Avenue SE
Lonsdale MN 55046
Tel: 507-744-3245
Fax: 507-744-3247

Northfield Clinic
2000 North Avenue
Northfield MN 55057 Tel:
507-646-1494
Fax: 507-646-6870

ENT Clinic-Faribault
1645 Lyndale Ave N #103
Faribault MN 55021
Tel: 507-333-5499
Fax: 507-333-5489

Express Care Clinic
706 Division Street
Northfield MN 55057
Tel: 507-646-6700
Fax: 507-646-6701

Women's Health Center
2000 North Avenue
Northfield MN 55057
Tel: 507-646-1478
Fax: 507-646-8101

Orthopedic Services - Northfield
1381 Jefferson Road
Northfield MN 55057
Tel: 504-646-8900
Fax: 507-646-8904

Northfield Hospital (includes EMS)
2000 North Avenue
Northfield MN 55057
Tel: 507-646-1101
Fax: 507-646-1394

Cancer Care & Infusion Center
2000 North Avenue
Northfield MN 55057
Tel: 507-646-6979
Fax: 507-646-1417

Long Term Care Center
2000 North Avenue
Northfield MN 55057
Tel: 507-646-1300
Fax: 507-646-1316

Orthopedic Services - Faribault
1645 Lyndale Ave N #103
Faribault MN 55021
Tel: 507-334-1601
Fax: 507-646-8946

Rehabilitation Services
1381 Jefferson Road
Northfield MN 55057
Tel: 507-646-8800
Fax: 507-646-8801

Rehabilitation Services
9913 214th Street, West
Lakeville MN 55044
Tel: 952-985-2020
Fax: 952-985-2025

Home Care & Hospice
1604 Riverview Lane
Northfield MN 55057
Tel: 507-646-1457
Fax: 507-646-1395

Northfield Eye Physicians & Surgeons
2019 Jefferson Road
Northfield MN 55057
Tel: 507-645-9202
Fax: 507-645-9203