Northfield Hospital + Clinics
2000 North Ave, Northfield MN 55057

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:
(check all that apply)
Addresses on the back

- ☐ Farmington Clinic
- ☐ Lakeville Clinic
- ☐ Lonsdale Clinic
- ☐ Northfield Clinic
- ☐ Faribault Clinic
- ☐ Express Care Clinic
- ☐ Cancer Care & Infusion Center
- ☐ Northfield Eye Physicians & Surgeons
- ☐ Orthopedic Services
- ☐ Rehabilitation Services
- ☐ Women's Health Center
- ☐ Home Care & Hospice
- ☐ Northfield Hospital (includes EMS)
- ☐ Diagnostic Imaging
- ☐ Long Term Care Center

Addresses on the back

3. Release Information To:
(allow 7-10 days to process this release)

Organization Name: _____ and/or Person Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone (optional): _____ Fax (optional): _____

Email: _____

4. Health Information to be Released:

☐ Pertinent Record Set (Two years of records will be sent)

- ☐ Discharge Summaries
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ History and Physical
- ☐ Lab Data, including:
- ☐ E.K.G. Reports
- ☐ Billing Records
- ☐ Outpatient Reports
- ☐ Radiology Images
- ☐ Radiology Reports
- ☐ Mammogram Images
- ☐ Consultation Reports
- ☐ Immunization Reports
- ☐ Office Visit Notes
- ☐ Other, including: _____

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:

- ☐ Chemical Dependency Program
- ☐ Psychotherapy Notes

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 no 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:

- ☐ Transfer of care
- ☐ Personal use
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Legal
- ☐ Disability determination
- ☐ Insurance
- ☐ Other:

7. Authorization:

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.

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".

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in Section 2.

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.

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.

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.

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.

I understand that this release will take effect on the date signed and will be in effect for one year.

_____ _____

Signature of Patient or Authorized Representative | Date of Signature

_____ _____

Printed Name of Patient or Authorized Representative | If other than patient, state relationship and authority to sign

R O I

Release of Information List:

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

Faribault Clinic
1980 30th Street NW
Faribault MN 55021
Tel: 507-333-5499 (ENT)
Tel: 507-334-1601 (Ortho)
Fax: 507-333-5489

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

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

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

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

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

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

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

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

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

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

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

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

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