WESTHEALTH
outpatient health care
2855 & 2805 campus drive
plymouth, MN 55441
phone 763-577-7000

Authorization for Release of Information

Copy Service may process records - OK to Photocopy

Medical Records Number:_____

PATIENT NAME: _____
Last First Middle Maiden or Other Name

DATE OF BIRTH:_____Social Security Number: _____
Month Day Year

ADDRESS: _____CITY:_____ STATE:_____ZIP:_____

DAY PHONE:_____EVENING PHONE:_____

I hereby authorize WestHealth, Inc. to release information from my medical record as indicated below to:

SELF or NAME of CLINIC, DOCTOR, or HOSPITAL:_____

ADDRESS:_____ CITY:_____STATE: ____ZIP:_____

PHONE:_____ FAX:_____ E-MAIL:_____

RECORDS NEEDED, DATE NEEDED

- ❑ All Record _____ All Dates
- ❑ Breast Center _____ _____
- ❑ Films-Radiographs _____ _____
  Originals must be returned
- ❑ Laboratory _____ _____
- ❑ Operative _____ _____
- ❑ Pathology _____ _____
- ❑ Radiology _____ _____
- ❑ Urgent Care _____ _____
- ❑ _____ _____

Only fill in this section if you need these specific records

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)*
- ❑ Marketing (except for face-to-face encounter)
- ❑ HIV related information (AIDS related testing)

_____ DATE: / /
Signature Of Patient Or Legal Guardian

* if this authorization is used for the purpose of psychotherapy notes, it must not be combined with any other authorization (s) unless for the purpose of psychotherapy notes

I UNDERSTAND THAT THE PURPOSE OF DISCLOSURE IS FOR THE FOLLOWING: Select Below

- ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care ❑ Insurance
- ❑ Legal ❑ Worker's Compensation ❑ School ❑ Research
- ❑ Other – Specify:_____

- I understand that this authorization will expire in 365 days, or _____after I have signed the form, and access to copies of requested records will be granted within 30 days, or sooner.
- I understand that I may revoke this authorization by notifying WestHealth, Inc in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that if the person or entity receiving Authorized information is not a health plan or health care provider covered by federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- My health care and payment for my health care will not be affected if I do not sign this form, and I understand that I may refuse to sign this authorization.
- I understand I may see/copy the information described on this form if I ask for it (permitted by Federal law or State), and that I will receive a copy of this form after I sign it.
- WestHealth, Inc in compliance with Minnesota State statute may charge a fee of $_____.

There is no charge for medical records if copies are sent to facilities for ongoing care or follow-up treatment.

_____ _____Or _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____ _____
Records Received By Date Relationship to Patient

FOR OFFICE USE ONLY ☐ Medical Records ☐ Radiology ☐ Registration ☐ Patient Picking Up ☐ Mailed Out ☐ Needs to be done

Date Request Filled:_____ Filled By: _____

Type of ID & Expiration: _____ Fee Collected: $ _____

Revised on 01/2008 White: MR Copy Yellow: Patient or Radiology copy