FAIRVIEW

Fairview Home Medical Equipment
Central Medical Records
2200 University Ave. W. Suite 110
St. Paul, MN 55114
Phone: 651-632-9800
Fax: 651-632-9801

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Please Print Clearly)
Patient Name_____ **Account #**_____

Previous Names _____ **Social Security #** _____ **Birth date** ____/____/____

Phone Numbers (Home) _____ **(Work)** _____ **(Other)** _____

❑ **This will authorize Fairview Home Medical Equipment to request information from** _____
(Other Healthcare Facility)

❑ **This will authorize Fairview Home Medical Equipment to release records to:**

Name/Organization

Street Address

City State Zip Code

The following information is to be released (check appropriate boxes):

❑ Evaluation
❑ Sleep Study
❑ Other (specify) _____
❑ Doctor's Orders

For the following date(s) of treatment or condition:_____
(Specify Dates Of Treatment Or Condition)

I am requesting this information be released for the following purpose:

❑ Continued care by another provider
❑ Insurance claim purposes
❑ Personal use
❑ Attorney review
❑ Other_____

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____
  Please indicate any restrictions. (Specify)_____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Fairview cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Except for research-related treatment, Fairview will not condition treatment on my signing this authorization.

_____ _____ _____
Signature of Patient/Authorized Person (If Authorized Person Is Signing, Please Also Print Name) | **Authorized Person's authority to sign** (Parent, Guardian, Power Of Attorney, etc.) | **Date**

REASON PATIENT IS UNABLE TO SIGN: ☐ **Minor** ☐ **Deceased** ☐ **Other:**_____

Original - Chart Copy Copy - Patient/Authorized Person

Completed on _____ by _____ via ☐mail ☐fax ☐other_____