MinnesotaHospice
THE GOLD STANDARD of Care

Authorization to Release Health Information

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____hereby authorize the release of personal health information to
Name of patient or personal representative

Minnesota Hospice regarding the following patient:

Patient Name:	Date of Birth:
Address:	Patient's Phone:

Disclosing Agency:	**Information to be provided to:**
Name of Facility/Title of Authorized Person	Name of Person/Organization/Facility
Address:	Address:
City/State:	City/State:

The purpose or need for this disclosure is (circle one):

Future medical care	Attorney	At the request of the patient
Personal use	Insurance	At the request of the personal representative
Disability	Research	Hospice

If the purpose is for marketing, will the company receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ Yes ☐ No

Information to be disclosed: The information to be disclosed includes only those items circled below, with respect to services provided by the company.

Discharge summary	Progress notes
Lab results	Photographs, videotapes, or other images
History and physical exam	Entire medical record
Consultation reports	X-Ray reports
HIV/AIDS test results and treatment	Summary of treatment
Alcohol/drug abuse treatment/referral	Mental health - other than psychotherapy notes

I understand that I may revoke this authorization in writing submitted at any time to the company, except to the extent that action has already been taken on this authorization or this authorization was obtained as a condition of obtaining insurance coverage or a policy in which case other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration even is stated below. *Specify new date:*_____

I understand that the company will not condition treatment or eligibility for care on my providing this authorization except if such care is research related.
I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

Signature of patient or personal representative (state relationship to Patient)	Date:
Signature of witness	Date: