AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION
INDIAN HEALTH BOARD OF MPLS- 1315 E. 24TH STREET MPLS, MN 55404
PHONE- 612-721-9800 FAX- 612-721-2904

Patient Contact Information	**NAME:** _____ **DATE OF BIRTH:** _____ **Phone Number:** _____
Releasing Party: Clinic/Hospital/Health Care Provider, Person, or Organization (***Who*** has the information you want released?) *CHECK ONLY ONE BOX	☐ **IHB of Mpls, 1315 E. 24th St., Minneapolis, MN 55404** ☐ **Allina EpicCare** ☐ **HCMC EpicCare** **NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone Number:** _____ **Fax Number:** _____
Receiving Party: Clinic/Hospital/Health Care Provider, Person, or Organization (**Who** will the information be sent to?)	☐ **IHB of Mpls, 1315 E. 24th St., Minneapolis, MN 55404** **NAME:** _____ **Address:** _____ **City:** _____ **State** _____ **Zip:** _____ **Phone Number:** _____ **Fax Number:** _____
Information to be Released (***What*** do you want sent or released? Check the appropriate box.) ***If requesting both medical and mental health records, you will need to fill out two separate releases.***	**Medical** **Dates of Service:** _____ ☐ Progress notes ☐ Radiology/Diagnostic Test reports ☐ Emergency record(s) ☐ Obstetrics report ☐ Operative Report ☐ Lab report(s) ☐ History & Physical exam ☐ Discharge Summary ☐ Entire record ☐ Other records specify: _____ **C&S / Mental Health & Chemical Health/Psychiatry Dates of Service:** _____ ☐ Diagnostic Assessment ☐ Treatment Plan ☐ Testing ☐ Discharge Summary ☐ Verbal Communication ☐ Medication Management-Psychiatry ☐ Social Work Services ☐ Other, specify: _____ **Dental: Dates of Service:** _____ ☐ X-Rays ☐ Office Notes ☐ Other records specify: _____
Release Instructions (***How*** and ***When*** do you want the information?)	**Release Method / Format requested: (check one)** ☐ Paper/ Mail ☐ Fax **(IF OVER 30 PAGES NOTIFY IHB)** ☐ Verbal Disclosures ☐ CD ☐ Paper/ Patient Pick up **(ID May be requested at the time of pick up)** ☐ Health Information Exchange (EpicCare)
Purpose of Release (***Why*** is it needed?)	☐ Continuing care /Treatment Planning ☐ Transfer of care ☐ Personal use or review * ☐ Litigation/legal/determination * + ☐ Other * _____ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 + Must be requested from legal representative

I understand this release may include, but is not limited to, that which involves treatment or testing for alcohol/drug abuse, sickle cell anemia, sexually transmitted diseases, including HIV/AIDS, or mental health issues, that were maintained while a patient at your facility on any date, as well as any correspondences. This authorization will only include records prior to the date of signature.

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Indian Health Board Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- The Indian Health Board will not restrict my treatment if I choose not to sign this authorization.
- The Indian Health Board cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, I release The Indian Health Board from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian's Signature | Date | Relationship to patient/ Authority to act on behalf of patient

Patient/Legal Guardian's Printed Name _____

Requesting provider:_____ (For clinical use only)

Revision 7/27/17

Indian HEALTH BOARD
COMMUNITY TRADITION WELLNESS

Directions for Completion of Form

Please note: ***IHB has up to 30 days to process your request.*
***Fill out one release per releasing party*

Patient Information: Individual whose information is being requested for and contact information for questions related to this release.

Releasing Party: Clinic/Hospital/Healthcare Provider: Identify who has the information you want release. **Please be as specific as possible. Check only one box or fill in the information completely.**

Examples: -Name of facility, location (Indian Health Board, MPLS)
-Provider/medical staff's name (Dr.Smith at MN Best Care Clinic)

Receiving Party: Clinic/Hospital/Health Care Provider, Person, or Organization
Please be as specific as possible.
Identify the Name, address, phone, fax and any other contact information of the individual who is *to receive* the information.

Information to Be Released: This section gives us the instructions for what information you want released.

-To disclose information pertaining on certain period/event- Identify the date range/year or procedure or diagnoses within the desired department.

Release Instructions: This tells us how you would like your information delivered.

-If you wish for us to fax this information, a working fax number along with a contact phone number is needed in the (Receiving Clinic) box.

-If you wish for us to mail this information, please make sure that the address you provide us (in the Receiving Clinic box) is current and accurate.

**If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section: "form on file for access by (person or relation) upon their specific request".

Purpose of Request: Please identify why you need a copy of your record.

-This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

-Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event.