grand itasca® Clinic & Hospital
Part of Fairview Health Services

1601Golf Course Road
Grand Rapids, MN 55744
Phone: (218)326-3401

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name_____ Previous Names_____
Address_____
Birthdate_____ Phone Number_____ MR#_____

PROVIDER [Who has the information that you would like released?]	Name: __Grand Itasca Clinic and Hospital_____ Address:__1601 Golf Course Road_____ __Grand Rapids, MN 55744_____ Phone:_(218)326-3401___ Outgoing Fax:_(218)999-1513__ Incoming Fax:_(218)999-1512__
REQUESTOR [Where do you want the information to be sent?]	Name:_____ Address:_____ _____ Phone: _____ Fax: _____ Delivery Preference: ☐U.S. Mail ☐Fed Ex ☐Fax ☐CD ☐Onsite pick up
INFORMATION TO BE RELEASED	☐ Clinic Notes ☐ Discharge Summary ☐ Immunizations ☐ History and Physical ☐ Exam Pathology Reports ☐ Consultation Reports ☐ X-ray/Radiology Reports ☐ Lab Results ☐ Films ☐ Operative Reports ☐ EKG/ ECHO Reports ☐ Emergency Services ☐ Other (please specify)_____ Dates of Treatment or Condition:_____
REASON FOR RELEASE	☐ Continued care by another provider ☐ Personal use ☐ Attorney review ☐ Insurance claim purposes ☐ Other (please specify)_____

- 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 initialing here:_____
- 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 _____(period of time, for example 2 days, or 3 weeks, or 5 months) from my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.
- 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, Grand Itasca Clinic & Hospital cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
- Except for research-related treatment, Grand Itasca Clinic & Hospital will not condition treatment on my signing this authorization.

Signature of patient / Authorized Person	Authorized person's authority to sign (Parent, guardian, power of attorney, etc.)	Date

If you have any questions, please call the Release of Information Desk at (218) 999 -1517