1935 County Road B2, Suite 100 | Roseville, MN 55113
Phone: 651-636-4155 | Fax: 651-636-3595 |www.rosenbergcenter.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: (First, Middle, Last) ________________________________ Date of Birth: (Month DD, YYYY) ____________________

Previous Name: (First, Middle, Last) ________________________________

I request and authorize the release of healthcare information of the patient named above **FROM:**

- ☐ Rosenberg Center, 1935 County Road B2, Suite 100, Roseville, MN 55113
- ☐ Other (specify facility/individual & address below, including phone/fax if known)

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I request and authorize the release of healthcare information of the patient named above **TO:**

- ☐ Rosenberg Center, 1935 County Road B2, Suite 100, Roseville, MN 55113
- ☐ Other (specify facility/individual & address below, including phone/fax if known)

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Release of Information

Purpose of Release

- ☐ Treatment/Continued care
- ☐ Disability determination
- ☐ Consult/second opinion
- ☐ Other _____________
- ☐ TEAM Evaluation
- ☐ Move
- ☐ Personal
- ☐ SSI appeal
- ☐ Application for insurance
- ☐ Insurance change
- ☐ Payment of insurance claim
- ☐ Legal purposes

Information To Be Released

- ☐ Clinic notes
- ☐ History and physical
- ☐ Therapy records
- ☐ Psychological testing
- ☐ Consult/follow-up records
- ☐ Medication list
- ☐ Other ___________________________
- ☐ Hospital notes
- ☐ Hospital discharge summary
- ☐ Immunization records
- ☐ Genetic testing
- ☐ Mental health records
- ☐ School records/IEP's/special education services
- ☐ EKG's
- ☐ Laboratory reports
- ☐ Pathology reports
- ☐ Radiology reports
- ☐ Billing information
- ☐ Chemical dependency records

Services dates (optional) From To	Information needed by (optional)

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II. 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization 3. I have the right to revoke this authorization at any time by writing to Freedom Health. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in Freedom Health, or eligibility benefits will not be conditioned upon my authorization of disclosure. 5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law. 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.

I authorize the above provider to release the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon receipt, Rosenberg Center will use the information for continuing my medical care and may release the information to other providers involved in my care. I understand there may be a charge for my records per Minnesota Statute 144.335.

This authorization shall be valid for 1 year from the date it is signed. I understand that I may revoke this authorization at any time.

Name: ______________________________________ Date: ________________________

Signature: __________________________________

Relationship to patient if patient is a minor: _____________________________________