Patient Information

Name _____ Office Use Only MRN _____

Date of Birth _____ Phone _____ Email _____

Release Information From

Name/Organization _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

Release Information To

Name/Organization _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

Reason For Release & Service Date(s) Requested

☐ Continuing care ☐ Workers Compensation ☐ School ☐ Personal use
☐ Insurance application ☐ Insurance payment/claims ☐ Legal ☐ Other _____

Service Dates Between _____ to _____

Information To Be Released

All Routine Records (these are routine records typically requested by a healthcare provider)

☐ Notes, History and Physical, Discharge Summary, Emergency Room, Lab, Radiology, Procedures, Test Results and Consultations

Select Individual Records (check all that apply)

☐ Discharge Summary
☐ History and Physical Exams
☐ Operative/Procedure Reports
☐ Rehab Reports (PT/OT/SP)
☐ Medication List
☐ Radiology Films/MRI
☐ Diagnostic Test Results
☐ Pathology Reports
☐ Progress/Provider Notes
☐ Emergency Reports
☐ Pathology Slides (sent directly to facility listed in step 3)
☐ Other (specify content and dates) _____
☐ Consultations
☐ Psychological Testing
☐ HIV/Aids Testing **(WI Only)**
☐ Billing Records
☐ Radiology Reports
☐ Laboratory Reports
☐ Forms Completion

Behavioral Health: All information regarding behavioral health will be released **unless** you restrict by initialing here: _____

Substance Use Disorder (SUD)

If requesting **Substance Use Disorder (SUD)** records, please initial here: _____

SUD Service Dates Between _____ to _____

☐ Notes ☐ Lab ☐ Other SUD (please describe the SUD information to be disclosed): _____

Date Needed By

Date: ____/_____/____

Note: We work diligently to complete requests as timely as possible. To check the on the status of your request, please email SM-EHStatus@datavant.com or call 866-203-7454.

Release Method

☐ MyChart ☐ Fax ☐ Email ☐ Mail Format (If Mailed): ☐ Paper ☐ Disc

- This authorization lasts for one year after the date you sign it unless you enter a different expiration date here: _____
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy regulations 42 CFR Part 2; HIPAA.
- I understand psychotherapy and SUD counseling notes will not be released per facility; HIPAA Privacy Rules 45 CFR 160, 164, 164.502; and 42 CFR 2.11, 2.31(b).
- I understand that Essentia Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.293, WI Statute 146.83, and NDCC 23-12-14, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.

Patient **Signature** and **Date** are required to release records. If an **Authorized Person** is signing you must include **legal documentation**.

_____ _____
Patient Signature *Date*

_____ _____
Signature of Authorized Person *Date*

Authorized Person Relation to Patient: ☐ Parent of Minor Patient ☐ Court-Appointed Guardian/Legal Custodian/Conservator or Other Authorized Personal Representative

Email: ReleaseOfInformation@EssentiaHealth.org

Mail to: Duluth Family Medicine Clinic
330 N 8th Ave E

Telephone Number: 218-723-1112

Fax Number: 218-529-9129

Duluth Family Medicine Clinic