Member information release form

Request date		
Member name	Member date of birth	Member ID
Member address		
Phone number	Email	

SECTION 1: Information to be released

Hennepin Health may release information to _____.
(the name of the entity or person to whom you want the information provided)

(Check the information you want to be released)

- ☐ My name
- ☐ Demographic information
- ☐ Claims
- ☐ Medication
- ☐ Alcohol and drug abuse treatment
- ☐ Care plans
- ☐ HIV/Aids
- ☐ Mental health
- ☐ Genetic testing
- ☐ Utilization review
- ☐ Restricted recipient information
- ☐ Service authorization
- ☐ Appeals and grievances
- ☐ Assessments
- ☐ Enrollment
- ☐ Financial
- ☐ Photographs, video, digital or other images
- ☐ Other, specify_____

The records checked above may be released for the following time period:_____.
(if no specific time period, leave blank).

SECTION 2: Reason for the release

(Check all that apply)

- ☐ Member request
- ☐ Research
- ☐ Review member's current care/treatment
- ☐ Insurance
- ☐ Payment
- ☐ Legal
- ☐ Appeal/grievance
- ☐ Continuity of care
- ☐ Media release
- ☐ Marketing
- ☐ Other, specify_____

This release will expire after one year from the date this form is signed unless I specify an earlier date, event or condition here: _____.

SECTION 3

By signing this form:

- I agree that Hennepin Health may use and release information about me as marked in **Section 1** for the reasons checked in **Section 2**.
- I have the right to cancel this release at any time by writing to Hennepin Health. I understand that information might have already been shared before I canceled the release.
- I understand that any information used or disclosed may no longer be protected by state or federal law. It may also be redisclosed by the person or entity receiving it.
- I understand that I do not have to sign this release. If I choose not to sign this release, it will not affect my health coverage.
- I understand that the information released about me may let others know that I am covered under a Minnesota health care program.
- If I am authorizing the release of 'photographs, video, digital, audio or other images' in **Section 1,** I understand and acknowledge that Hennepin Health and Hennepin County retain all right, title and interest in any of the information, media, or images including but not limited to photographs or like images of me, any audio or audiovisual recordings or any written or other forms of media as may be released or used in accordance with this signed release.
- I release Hennepin Health from any and all liability or claims arising out of the use of the released information.

_____

Member signature Date

_____

Member guardian or authorized representative signature (if applicable) Date

_____

Relationship to member

Return form to:
Hennepin Health
400 South Fourth Street, Suite 201
Minneapolis, MN 55415
612-904-4267

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