PATIENT AUTHORIZATION
FOR RELEASE OF INFORMATION

TO: Hennepin Health
400 South 4th Street, Suite 201
Minneapolis, MN 55415

Re: _____
(Patient's name)

_____
(Date of birth and/or Soc. Sec. No.)

This Release of Information form is your full and sufficient authorization, pursuant to Minn. Stat. Section 144.335 and HIPAA 45 CFR 164.508(c)(1), to release to:

_____

all my medical information (including but not limited to that which involves treatment for alcohol or drug abuse, sickle cell anemia, or mental problems) in your possession, with the following exceptions:

_____

The information is needed for the purpose of:

_____

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding (including claims and potential claims). I do not authorize re-release of this information by the third party. I understand that I may refuse to sign this authorization but that my refusal will prevent Hennepin Health from acting on my behalf (re: above stated purpose) and may include the inability of Hennepin Health to issue payment for my claims or arrange for my health care services.

I understand that I may revoke this consent in writing at any time, but that such revocation may adversely affect the course of the proceeding requiring these records. Upon the fulfillment of the above stated purpose, this consent will automatically expire without my express revocation. Under no circumstances will this authorization continue more than one year from the date of my signature below. A photocopy of this authorization will be treated in the same manner as an original. Conversations by the bearer of this authorization with physicians, however, <u>are/are not</u> authorized by this release form **(strike one)**.

_____
Signature of Patient/Guardian Date

_____
Relationship to Patient

_____
Reason Patient Unable to Sign

I verify that the proceeding requiring this information is still pending and that information provided pursuant to this authorization will not be re-released for purposes not related to this proceeding.

_____
Signature of Party Requesting Information Date