colon& rectal surgery associates

A DIVISION OF

MINNESOTA ONCOLOGY

# Authorization for Disclosure of Protected Health Information

***Minnesota Oncology use only***

Received:

Date: _____ Initials: _____ Ext: _____

Processed by: _____

Items Sent: ☐ All Requested ☐ Partially fulfilled (see Response to Records Request form)

***Instructions:*** *Any incomplete section invalidates this form and the request cannot be processed*

| Patient Name (First, Middle, Last) | | | Patient DOB (Month, DD, YYYY) |
|---|---|---|---|
| Mailing Address of Patient–Street | | | |
| City | State | ZIP Code | Phone |

Minnesota Oncology, 2550 University Ave W. Suite 110N, St Paul, MN 55114
Phone: 651-414-3100 Fax: 651-414-3101

**Release Information From** *(who has your records)*

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

**Release Information To** *(who needs your records)*

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

**Information to be Released** (include dates of service if known; if no date of service included you will receive two (2) years of records)

☐ Office Notes ☐ Radiation Therapy Notes ☐ Pathology ☐ Billing Records
☐ Lab Reports ☐ Infusion/Treatment Record ☐ Radiology Reports ☐ Radiology Films *(Minnesota Oncology clinics only)*
☐ Other (specify content & dates): _____

**Information Needed By** (Date) :_____

• Chemical dependency/Substance abuse and/or Mental health records will be released unless indicated here. ☐ Do not release.

**Purpose of Release**

☐ Treatment / Continued Care ☐ Disability Determination ☐ Insurance Purposes
☐ Personal Use ☐ Litigation ☐ Other_____

I understand the expiration date of this authorization is **1 year** from the date of signing unless I indicate an earlier date or event here_____.

- I understand information created within 12 months after the date this authorization is signed, as well as past information may be released.
- I understand I may revoke this authorization at any time by notifying the providing organization in writing. Revoke effective on the date notified; except to the extent action has already been taken in reliance on it. Or reference to it.
- I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand Minnesota Oncology may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand a photocopy or fax of this form is the same as the original.

| **Patient or Legal Representative Signature** | **Date Signed (Month, DD, YYYY)** |
|---|---|
| **Printed Name of Patient or Legal Representative** | |

## Minnesota Oncology

## Please read the following information regarding this form

To request your health care records please complete this form. Records requests require a minimum of five business days to complete.

A courtesy copy of your records will be provided to you at no cost. A charge may be incurred for additional requests in abidance with Minnesota state law.

**Please Note:**
**This is a legal document. An incomplete form cannot be accepted. If you have questions about completing this form, please contact the Health Information Department at 651-414-3100.**

If you are the patient's legal representative, please **attach a copy** of the document that gives you the authority to request the patient's protected health information.

Your signature authorizing disclosure of medical information on the front side of this document indicates your review and understanding of the information described above.

You are entitled to a copy of this document.

**Contact Info for Patient Record Copies:**

Centralized Health Information Department
2550 University Ave W, Suite 110N
St. Paul, MN 55114
Phone: 651-414-3100
Fax: 651-414-3101