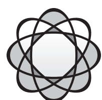

MINNESOTA ONCOLOGY

Caring, down to a science.®

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 Hematology, P.A, 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 *(St Paul, Maplewood clinics only)*
☐ Other (specify content & dates): ____________________________________

____

Information Needed By (Date) :____________________________________

Purpose of Release

☐ Treatment / Continued Care ☐ Disability Determination ☐ Insurance Purposes
☐ Personal Use ☐ Litigation ☐ Other (please explain)________________

____

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. 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 Minnesota Oncology Hematology, P.A. 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.

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____.

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

Minnesota Oncology Hematology, P.A.

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