HealthEast Care System

Authorization For Release Of Information

☐ Allergy Care (1690 University Ave. W, #450, St Paul MN 55104)
☐ Cottage Grove Clinic (6936 Pine Arbor Dr. S, 55016)
☐ Downtown St. Paul Clinic (17 W. Exchange St, 55102)
☐ Eagan Clinic (1215 Town Centre Drive, 55123)
☐ Hugo Clinic (14688 Everton Avenue, 55038)
☐ Macalester/Groveland (45 N. Snelling, St. Paul, 55104)
☐ Maplewood Clinic (3100 Kennard St, 55109)
☐ Midway Clinic (1690 University Ave. W., #570, St. Paul, 55104)
☐ Oakdale Clinic (1099 Helmo Ave. N., #100, 55128)
☐ Rice Street Clinic (980 Rice Street, St. Paul, 55117)
☐ Roselawn Clinic (1983 Sloan Place, St. Paul, 55117)
☐ St. Anthony Park (2315 Como Ave., St. Paul, 55108)
☐ Vadnais Heights Clinic (1055 Centerville Circle, 55127)
☐ Woodbury Clinic (1875 Woodwinds Dr., 55125)

❑ **I Hereby Authorize HealthEast** _____ **to REQUEST information FROM:**
(select from above)

_____
(facility name and address)

❑ **I Hereby Authorize HealthEast** _____ **to RELEASE information TO:**
(select from above)

Name _____ Phone # _____

Address: _____

Regarding the Following Patient:

Name _____ Phone # _____

Other Names _____ Date of Birth _____

Address _____ SSN # _____

Records to be Released:

Date(s) treatment was received:_____

☐ Consultative Report
☐ Operative Report
☐ X-Ray Film
☐ Entire Record
☐ History and Physical
☐ Pathology Report
☐ X-Ray Report
☐ Certified Copy
☐ Laboratory Report
☐ Progress Notes
☐ Photographs, Videos Digital or Other Images
☐ Other_____

I authorize the release of information relating to:
☐ HIV/AIDS Testing/Treatment ☐ Psychiatric Evaluation/Treatment ☐ Alcohol/Drug Abuse Evaluation/Treatment

Purpose of Release:

☐ Continuing care for ongoing treatment ☐Transfer of Care ☐ Insurance ☐ Personal Use ☐Other_____

This authorization expires on the following date, event or condition: _____.
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:

- I understand that, except for research-related treatment, HealthEast will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____ _____
Relationship to Patient Reason Patient Unable to Sign

_____ _____
Signature of Witness (Verbal Authorization Only) Signature of Witness (Verbal Authorization Only)

----------For Office Use Only----------

Medical Records Released By:_____ Date:_____ MR#_____ ☐ Copies ☐ Review