HealthEast Care System

HealthEast Release of Information Services (ROI)
University Park Medical Building, Suite 180
1690 University Ave. W.
St Paul, MN 55104
Phone: 651-232-4999 Fax: 651-232-4887

Please see the HealthEast website (www.healtheast.org) for a list of locations.
Go to www.mychart.healtheast.org to learn how to access your personal health information online.

1. **Regarding the Following Patient:**

Patient Name_____ Phone #_____

Other Names_____ Date of Birth_____

Address_____
Street *Apt.* *City* *State* *Zip*

2. **REQUEST Information FROM:** _____
Facility name

Address/Phone #_____

3. **RELEASE Information TO:** Fax #:_____
Provider to Provider Only

Name_____ Phone #_____

Address_____
Street *Apt.* *City* *State* *Zip*

4. **Records to be Released:** **Date(s) treatment was received**: _____

☐ Consultation Report	☐ Laboratory Report	☐ Radiology Reports	☐ Other_____
☐ Discharge Summary	☐ Office Notes	☐ Radiology Image Film/CD	
☐ Emergency Room Report	☐ Operative/Procedure Report	☐ Test Results	
☐ History and Physical	☐ Pathology Report	☐ Verbal Discussion Only - **Do Not release any written records**	
☐ Physician Progress Notes	☐ Mental/Behavioral Health Records	☐ Immunizations	

How do you want to receive your information? Select Media Type: ☐ Paper ☐ Electronic (Flash Drive/CD)

5. **The following information requires special consent by law.** Even if you indicate **all health information,** you must specifically request the following information in order for it to be released

I authorize the release of the information relating to: ☐ Chemical Dependency Program Records ☐ Genetic Testing/Evaluation

6. **Purpose of Release:** ☐ Continuing/Transfer of Care ☐ Insurance ☐ Litigation ☐ Personal Use ☐ Sale of PHI ☐ Other_____

7. **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. **A new Authorization will be required for each new episode of care**.
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 Management/Release of Information. 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.
- HealthEast's records may include records that we received from other organizations. If these records have been used by HealthEast and filed in the record HealthEast maintains about you, these records may be released with your HealthEast records.

8. _____ _____
Signature of Patient/Legally Authorized Representative Today's Date

_____ _____
Relationship to Patient Reason Patient Unable to Sign

_____
Signature of Witness (Verbal Authorization Only)

☐ Copies ☐ Review ☐ CD/Image