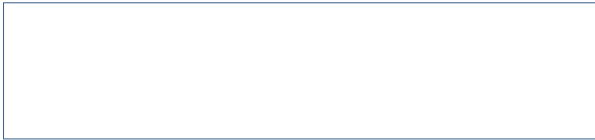




HealthEast Release of Information Services (ROI)
University Park Medical Building, Suite 180
1690 University Ave. W.
St Paul, MN 55104
Phone: 651-232-4999 Fax: 651-232-4887



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.	<p>Regarding the Following Patient:</p> <p>Patient Name _____ Phone # _____</p> <p>Other Names _____ Date of Birth _____</p> <p>Address _____</p> <p style="text-align: center;"><i>Street Apt. City State Zip</i></p>
2.	<p>REQUEST Information FROM: _____</p> <p style="text-align: center;"><i>Facility name</i></p> <p>Address/Phone # _____</p>
3.	<p>RELEASE Information TO: _____ Fax #: _____</p> <p style="text-align: right;"><i>Provider to Provider Only</i></p> <p>Name _____ Phone # _____</p> <p>Address _____</p> <p style="text-align: center;"><i>Street Apt. City State Zip</i></p>
4.	<p>Records to be Released:</p> <p><input type="checkbox"/> Consultation Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Discharge Summary <input type="checkbox"/> Office Notes <input type="checkbox"/> Radiology Image Film/CD</p> <p><input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Operative/Procedure Report <input type="checkbox"/> Test Results</p> <p><input type="checkbox"/> History and Physical <input type="checkbox"/> Pathology Report <input type="checkbox"/> Verbal Discussion Only - <u>Do Not release any written records</u></p> <p><input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Mental/Behavioral Health Records <input type="checkbox"/> Immunizations</p> <p>How do you want to receive your information? Select Media Type: <input type="checkbox"/> Paper <input type="checkbox"/> Electronic (Flash Drive/CD)</p>
5.	<p>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</p> <p>I authorize the release of the information relating to: <input type="checkbox"/> Chemical Dependency Program Records <input type="checkbox"/> Genetic Testing/Evaluation</p>
6.	<p>Purpose of Release: <input type="checkbox"/> Continuing/Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Litigation</p> <p style="text-align: center;"><input type="checkbox"/> Personal Use <input type="checkbox"/> Sale of PHI <input type="checkbox"/> Other _____</p>
7.	<p>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.</p> <p>Statement of Authorization:</p> <ul style="list-style-type: none"> ▪ 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.	<p>Signature of Patient/Legally Authorized Representative _____ Today's Date _____</p> <p>Relationship to Patient _____ Reason Patient Unable to Sign _____</p> <p>Signature of Witness (Verbal Authorization Only) _____</p>

