

## AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_

**I hereby authorize:**

release information to:  exchange information with:

<b>NAME:</b> Capitol Park Mental Health Hospital	<b>NAME:</b>
<b>ADDRESS:</b> 559 N Capitol Blvd	<b>ADDRESS:</b>
Saint Paul, MN 55103	
<b>PHONE:</b> 763-237-6800 <b>FAX:</b> (763) 356-4097	<b>PHONE:</b> <b>FAX:</b>

By signing below, I hereby authorize Capitol Park Mental Health Hospital or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

**The following information is requested: (patient\* or legal guardian  items to be released).**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Psychiatric Evaluation      | <input type="checkbox"/> Laboratory Reports                    | <input type="checkbox"/> Financial Account information |
| <input type="checkbox"/> History & Physical          | <input type="checkbox"/> Immunization Records                  | <input type="checkbox"/> Complete Medical Record       |
| <input type="checkbox"/> Practitioner Orders         | <input type="checkbox"/> Medication Records                    | <input type="checkbox"/> Date(s) of Service _____      |
| <input type="checkbox"/> Practitioner Progress Notes | <input type="checkbox"/> Treatment/Individualized Service Plan | <input type="checkbox"/> Other (specify) _____         |
| <input type="checkbox"/> Discharge Summary           | <input type="checkbox"/> Discharge Instructions                | _____  |

**The Purpose or Need for Disclosure is:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> To Transfer Client Care | <input type="checkbox"/> To Aid in Treatment       | <input type="checkbox"/> Application for Provider Coverage    |
| <input type="checkbox"/> For Follow Up Care      | <input type="checkbox"/> For Discharge Planning    | <input type="checkbox"/> Psychological Report                 |
| <input type="checkbox"/> To Inform Family        | <input type="checkbox"/> To Update Medical Records | <input type="checkbox"/> To Aid in financial account activity |
| <input type="checkbox"/> Referral Source         | <input type="checkbox"/> Employer                  | <input type="checkbox"/> Other (specify) _____                |
| <input type="checkbox"/> Legal/Court System      |  | _____   |

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *State and federal law protect the following information. If this information applies to you, please () indicate if you would like this information released/obtained* (include dates where appropriate):

- Alcohol, Drug, or Substance Abuse Records  Yes  No Dates: \_\_\_\_\_  
 HIV Testing and Results  Yes  No Dates: \_\_\_\_\_  
 Mental Health Records Dates:  Yes  No Dates: \_\_\_\_\_

**Disclosure Format (Paper/US Mail or Fax is default if not marked.):** Specify "E-mail" or other Electronic format": \_\_\_\_\_

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on \_\_\_\_\_ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.
- I understand that Capitol Park Mental Health Hospital will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantages of disclosing such information. I hereby release the above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

\_\_\_\_\_  
 Patient or Authorized Representative Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name Relationship to Patient (if applicable).