

# Carris Health

## Authorization for Release of Health Information

Please see Directions for additional information on completing.  
Please Print

<b>Patient Information</b>	Name	Date of Birth	
	Address	Phone Number	
	City	State	Zip Code
	Previous Name		
<b>Release Information From</b>	Specific Carris Health Clinic / Hospital or Provider		
	Address	Phone Number	
	City	State	Zip Code
<b>Release Information To</b>	Name of Person, Business, Specific Clinic / Hospital or Provider		
	Address	Phone Number	Fax Number
	City	State	Zip Code
<b>Information to Be Released</b> Only the information check marked will be released	<b>Date(s) of service: From: _____ To : _____</b>		
	<b>Note: If dates are not specified, only the most recent visit/encounter will be released.</b> <input type="checkbox"/> History and Physical <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Consult Reports <input type="checkbox"/> *Radiology Films <input type="checkbox"/> Emergency Room Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> All Records (*not included) <input type="checkbox"/> Progress Notes <input type="checkbox"/> Operative/Procedure Notes <input type="checkbox"/> Assessment/Evaluation <input type="checkbox"/> Other (please specify) _____		
<b>Special Disclosure</b>	<input type="checkbox"/> Substance Use Disorder      Dates of Service: From: _____ To: _____ Concerning: _____ (Specific diagnosis or treatment – do not list ICD-10 codes) <i>Per Federal Rule 42 CFR Part 2, this section must be completed to release Substance Use Disorder records.</i>		
<b>Preferred Method</b>	<input type="checkbox"/> MyChart (If you do not have MyChart access, please visit <a href="http://www.carrishealth.com">www.carrishealth.com</a> ) <input type="checkbox"/> CD <input type="checkbox"/> Paper <input type="checkbox"/> Other _____		
<b>Reason for Release</b>	<input type="checkbox"/> Continuation or Transfer of Care (to another provider) <input type="checkbox"/> Personal Use <input type="checkbox"/> Attorney <input type="checkbox"/> Insurance <input type="checkbox"/> Other (specify) _____		
<b>Authorization</b>	Patient/Guardian Signature	Date	
	Relationship to Patient	Reason Patient is Unable to Sign	
<b>Revocation</b>	This authorization will expire one year from the date of signature unless I indicate a different date or event here: _____ This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.		

Carris Health will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. Once released, the information will no longer be covered under the Federal Privacy Laws. Information not originated by Carris Health cannot be released to another facility. I understand that my medical record is part of the Carris Health (CH) Electronic Medical Record. Carris Health shares an electronic medical record with non-CH organizations. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record. A list of these non-CH organizations will be provided to the patient upon request.



## Directions for Completion of Carris Health Authorization for Release of Health Information

**Patient Information:** Complete the entire section which identifies clearly the demographic information specific to the patient (individual who information is being requested for).

**Release Information From:** Identify which Carris Health hospital, clinic, or provider you are seeking information from. Please be specific in your request. Please see [www.carrishealth.com](http://www.carrishealth.com) for a listing of all Carris Health hospital and clinic locations.

**Release Information To:** Identify the full name of individual, business, hospital, clinic, or provider you want to receive your records. Be sure to include their address and phone number.

**Information to Be Released:** This section gives us the instructions for what information you want released. It is very helpful to identify the date or range of dates needed. If you do not have dates noted, only your last hospital encounter or clinic visit at the specific Carris Health location you indicated will be released. Only the specific information checked will be released.

**Special Disclosure:** This section is required per Federal Rule 42 CFR Part 2 to be completed in full to allow Carris Health to release Substance Use Disorder records. Even if you have indicated dates in the Information to be Released section, the dates of Substance Use Disorder records to be released is required in this section.

**Preferred Method:** This tells us how you would like your information provided. We can print the records, burn them to a CD, or release them to your MyChart portal. Note: If your original records are on paper, we are only able to provide them on paper.

**Reason for Release:** Please identify the reason you need a copy of your record. This helps us track and assign a priority status to your request. It also informs us determine who may be responsible for the cost of records (where applicable).

**Revocation:** This authorization will automatically expire 1 year after your signature unless you indicate another date or event upon which the authorization should expire OR you provide a written revocation to our organization.

Please send your completed authorization to: **Attn: Release of Information; Health Information Management Department** at the appropriate site listed below or drop off at any Carris Health location to be routed to appropriate site.

**Carris Health - Clinics**  
**Willmar Main Clinic (formerly APMC)**  
101 Willmar Ave. SW  
Willmar, MN 56201  
Phone: 320-231-5011  
Fax: 320-231-6323  
e-mail: [carriswiroi@carrishealth.com](mailto:carriswiroi@carrishealth.com)

**Carris Health - Rice Memorial  
Hospital**  
301 Becker Ave. SW  
Willmar, MN 56201  
Phone: 320-231-4680  
Fax: 320-231-4833  
e-mail: [rmhroi@carrishealth.com](mailto:rmhroi@carrishealth.com)

**Carris Health - Redwood Hospital**  
1100 E Broadway  
Redwood Falls, MN 56283  
Phone: 507-637-4591  
Fax: 507-697-6006  
e-mail:  
[rwfroi@carrishealth.com](mailto:rwfroi@carrishealth.com)

**Carris Health – Willmar Surgery  
Center**  
1310 S 1<sup>st</sup> St  
Willmar, MN 56201  
Phone: 320-262-7867  
Fax: 320-235-7069