MULTICARE ASSOCIATES
MEDICAL CENTERS

Blaine Medical Center 11855 Ulysses St. NE, Blaine, MN 55434
763-785-4200 • Fax 763-785-8424

Fridley Medical Center 480 Osborne Rd NE, Fridley, MN 55432
763-785-4500 • Fax 763-785-3329

Roseville Medical Center 1835 County Rd C-West, Roseville, MN 55113
763-785-4300 • Fax 763-785-7716

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	**NAME:**_____ **DATE OF BIRTH:**_____ **Address:**_____ **Day Phone:** (_____)_____ **City:**_____**State**_____ **Zip**_____
Clinic/Health Care Provider - (***Who*** has the information you want released?) **Please list the specific clinic.**	**NAME:**_____ **Address:**_____ **Day Phone:** (_____)_____ **City:**_____**State**_____ **Zip**_____
Receiving Party (***Where*** do you want the information sent?) **Clinic, Specialist,**_____ _____	**NAME:**_____ **Attention to:**_____ **Address:**_____ **Day Phone:** (_____)_____ **City:**_____**State**_____ **Zip**_____ **Fax Number (if records need to be faxed)** (_____)_____
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	**Records to be released** (A current year of records will be released unless otherwise specified below. There is a fee for copying more than two years of records.) _____ ____ Routine records: This includes office visits, lab, radiology, medications and immunizations ____ Copies of films/images **OR** ____ Release all record types checked below: ☐ Hospital ☐ Radiology reports ☐ OB/GYN ☐ Medication records ☐ History & physical exam ☐ Laboratory reports ☐ Immunizations ☐ Chemical dependency/ Substance abuse records ☐ Operative report ☐ Mental health records ☐ Pathology reports ☐ Consultations ☐ Progress notes/clinic notes ☐ Other records:_____ _____Please note that records related to mental health, HIV, alcohol and/or drug treatment will be released unless a check mark is place here. **OPTIONAL Limits - Disclose only records related to the following:** **Date(s) of service:** **Injury or illness:**
Release Instructions (***How*** and ***When*** do you want the information?)	Date information is needed:_____**(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)** ☐ Mail ☐ Pick up at Clinic
Purpose of Release (***Why*** Is it needed?)	☐ **Continuing care** ☐ **Transfer of care** ☐ **Social Security appeal** ☐ **Insurance application*** ☐ **Personal use or review*** ☐ **Social Security disability determination*** ☐ **Insurance payment/claim** ☐ **Litigation/legal*** **Other***_____ *** Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524**

ACKNOWLEDGEMENT OF UNDERSTANDING:

- **This authorization will last for one year from date of signature** or for a lesser period if specified here:_____ Initials_____.
- I may revoke this authorization at any time by providing notification in writing to Multicare Associates, and it will be effective on the date received except to the extent action has already been taken.
- A copy or faxed copy of this authorization will be treated in the same manner as the original.
- When Multicare Associates discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent re-disclosure, and the information may no longer be protected by federal privacy rules.
- By signing this authorization, I agree to allow Multicare Associates and all their staff members to disclose the following PHI to the above stated persons(s) or entity.
- By signing this authorization I agree to all its contents and release Multicare Associates from any and all liability resulting from re-disclosure.
- I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

_____ _____ ☐ Parent ☐ Legal Representative

SIGNATURE (Patient or Legal Representative) DATE (ATTACH LEGAL DOCUMENT)

(AGE 18 OR OVER MUST SIGN FOR RELEASE OF THEIR RECORDS)