NORTH MEMORIAL HEALTH
3300 Oakdale Ave. N
Robbinsdale, MN 55422

Authorization for Release of Information

MAPLE GROVE HOSPITAL
9875 Hospital Drive
Maple Grove, MN 55369

CUSTOMER INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Provider (*WHO* has the information you want to be released?) Please list specific hospital and/or clinic location.	NAME: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Receiving Party (*WHERE* do you want the information sent? *WHO* may have the information?)	NAME: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number (Only for urgent customer care requests)_____
Information to be Released (*WHAT* do you want sent or released? Check all appropriate items that apply.)	Information to be released includes records from the following dates: _____ ____Cardiac Test Results ____History & Physical ____Physician Progress Notes ____Consultation Reports ____Laboratory Reports ____Radiology Films ____Discharge Summary ____Nurses Notes ____Radiology Reports ____EKG Reports ____Operative Reports ____Billing Records ____Emergency Reports ____Pathology Reports ____Other (specify): _____ Reports released may include sensitive information such as mental status/chemical dependency, HIV/STD or pregnancy testing results. If there is specific information that you do not want released, please write here:
Purpose of Release (*WHY* is it needed?)	The information is needed for the following purpose: _____
Release Instructions (*HOW* and *WHEN* do you want the information?)	Date information is needed: _____(Please allow adequate time for processing) ☐ Mail ☐ MyChart ☐ Courier ☐ Review only ☐ FAX ☐ DVD (☐ mail) ☐ Encrypted Email (address) ☐ Unencrypted Email (address)_____ Note: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and there's a potential risk it could be intercepted and viewed by a third party. North Memorial Hospital and Maple Grove Hospital is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.

This authorization will expire upon the earliest of the following dates: 1) the date the stated purpose is fulfilled 2) the date I write here _____ 3) the date that I revoke this authorization. If not otherwise stated, this will expire one year from the date signed. I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that North Memorial Health and Maple Grove Hospital has relied on the authorization. A photocopy or facsimile of this authorization shall be treated as valid as the original. I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

_____ Date_____
Signature of Customer or Customer's Representative — Must be filled in

If Customer's Representative, under what legal authority are you signing?
• Parent • Guardian • Health Care Agent • Other (specify): _____

Not required to sign this authorization in order to receive treatment

Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524