For Processing Use:

INSTRUCTIONS FOR STANDARD CONSENT TO RELEASE HEALTH INFORMATION

IMPORTANT: Please read all instructions and information before completing and signing the form.
An incomplete form may not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact (651)213-5662.

A fee may be charged for the release of health information.

The following are instructions for each section of the attached form. Please type or print as clearly & completely as possible.

1. Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III) please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record number or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent out.

2. If there are questions about how this form was filled out, this section gives the holder of the records (currently Chisago County) permission to speak to the person listed in this section. **Completing this section is optional.**

3. In this section, indicate who is sending your health information. Please be as specific as possible. If you want to limit what is sent, you can name a specific facility, for example, Main Street Clinic; or name a specific professional, for example, Therapist John Jones. Please use the specific lines. Providing location information may help make your request clearer. Please print "All my Riverwood Centers providers" in this section if you want all your health information from Riverwood Centers released.

4. Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as fax submission of completed requests is not always possible. A space has been provided to indicate a deadline for providing the health information. Providing a date is optional.

5. Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the space provided.

   For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form. **EXAMPLE**: JD All health information

   If you select **All Health Information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

IMPORTANT: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and received federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of Page 1.

Psychotherapy notes are notes kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your health information. For the release of psychotherapy notes, you **MUST** complete a separate form noting only that category. Release of psychotherapy notes includes both written and oral information. If you do not want to give permission for persons holding the data to talk with persons to whom the data is to be released about your health information, you need to indicate that in this section.

Riverwood Centers Records
Consent Form to Release Health Information

For Processing Use:

1. Patient Information

First _____ Middle _____ Last _____

Patient date of birth: __/__/___ Previous Name(s) _____

Home address _____

City _____ State _____ Zip Code _____

Daytime phone: _____E-mail address (optional) _____

Required: Last four (4) digits of Social. Security No. _____ Medical Record /Patient ID (optional) _____

2. Contact for information about how this form was filled out (optional).

I give permission for the organization(s) [listed in section 3] permission to talk to:

First name _____ Last name _____ about how this form was completed. This person can be reached at: Daytime phone _____ E-mail address (optional)_____

3. I am requesting that health information be released FROM at least one of the following.

Organization(s) name __Five County Mental Health (Riverwood Centers); records currently in possession of Chisago

Healthcare facility or location(s): _____

Specific health care professional's name(s) _____

4. I am requesting that health information be sent TO:

Organization(s) name _____

And/or person: First name: _____Last_____

Mailing Address_____

City: _____ State: _____Zip Code_____

Phone (optional): _____Fax: _____ E-mail address (optional): _____

Information needed by (date) __/__/__ (optional): _____

5. Information to be released - IMPORTANT – indicate only information you authorize be released:

__ Specify years/dates of treatment: _____

__**ALL** Health information (see description of what is included)

OR

__ History/Physical	__ Mental Health	__ HIV/AIDS testing
__ Lab Report	__ Discharge Summary	__ Radiology Report
__ Emergency Room Report	__ Progress Notes/Reports	__ Radiology Images
__ Surgical Report	__ Care Plan	__ Photos, video, digital, other images
__Mediations	__ Immunizations	__ Billing Records

☐ Other information or Instructions: _____

The following information requires special consent by law. Even if you indicate "**ALL Health Information**" you must specifically request the following information for it to be released:

__ Chemical Dependency Program records (See Instruction Sheet for definitions & additional instruction)

__ Psychotherapy Notes (**CANNOT** be combined with this Release; Ask for Psychotherapy Instruction Sheet and Authorization Form.)

6. Health Information includes written and oral information.

By indicating any of the categories in section 5 (above), you are giving permission for **written information** to be released **and** for a person asked to release data (section 3) to talk to persons receiving data (section 4) about your health information. If you **do not** want to give your permission for a person releasing data (section 3) to talk to a person receiving (identified in section 4) about your health information, indicate that here (check mark or initials) _____.

7. Reasons for Releasing Information:

☐ Patient's request
☐ Review Patient's Current Care
☐ Treatment/Continued Care
☐ Payment
☐ Other (please explain)
☐ Insurance application
☐ Legal disclosure/production of records
☐ Appeal/Denial of Social Security Disability income or benefits
☐ Marketing Purposes (Payment? __ no; __ yes. If yes – amount $_____)

8. Acknowledgement. I understand that by signing this form, I am requesting that the health information specified in section 5 be sent to the third party identified in section 4 above.

___ I understand I may stop this consent at any time by writing to the organization holding the Records at:

Chisago County Health and Human Services
313 North Main, Rm 239
Center City, Minnesota 55012 **E-Mail: RWrecords@co.chisago.mn.us** **PH: (651)213-5662** **FAX: (651)213-5685**

If the organization named in section 3 has already released health information based upon my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they may not condition treatment payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicated an earlier date or event here:
Alternative end date for this release: __/___/_____ Or specific event: _____
MM/DD/YYYY

9. Patient's Signature. _____ Date __ / ___ / ____
MM MM YYYY

OR
Legally authorized representative's signature: _____ Date ___ / ___ / ____
MM MM YYYY

Representative's name printed:_____ _____
Representative's relationship to patient (parent, guardian, etc.) _____
Representative's address, telephone, fax and email _____
_____

Chisago County Health and Human Services
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Center City, Minnesota 55012 **E-Mail: RWrecords@co.chisago.mn.us** **PH: (651)213-5662** **FAX: (651)213-5685**