Stellis Health

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL INFORMATION

See reverse side for directions on how to complete and submit this form

Patient Identity	Name _____ Date of Birth _____ Previous Name(s) _____ Address _____ City _____ State _____ Zip _____ Phone # _____
Release my records from: *(Name of clinic/ hospital **who** will be **releasing** your records)*	Name _____ Address _____ City _____ State _____ Zip _____ Phone # _____ Fax # _____
Release my records to: *(**Who** will be **receiving** your records)*	☐ I would like my records sent: Name _____ Address _____ City _____ State _____ Zip _____ Phone # _____ Fax # _____ ☐ I would like my records released to my **MyChart** account. (Please note that for radiology, the imaging reports can be released via MyChart, not the actual images.) ☐ I would like to pick up my records at Stellis Health located in: ☐ Buffalo ☐ Monticello ☐ I would like my records delivered through secure email.
Information to be Released *(**What** do you want sent or released?)*	☐ **ALL RECORDS** Specify Date Range _____ to _____ or specify…. ☐ Visit Notes ☐ OB Reports ☐ Lab/Path ☐ EKG/Cardiac Tests ☐ Procedure Reports ☐ Other _____
RADIOLOGY DEPARTMENT	Specify Date Range _____ to _____ Specify Type of X-ray (e.g. foot, wrist) _____ ☐ X-ray Report ☐ X-ray Images/CD ☐ Mammograms ☐ MRA ultrasound done at Buffalo or Monticello Clinic
SENSITIVE RECORDS	***The following types of medical records are federally protected and require your very specific consent to release.*** **I AUTHORIZE** the release of the following information (please check all that apply) ☐ Mental Health/depression/anxiety ☐Chemical/Alcohol use abuse ☐Pain/Narcotic Contract ☐STD/HIV/AIDS
Reason for Disclosure	☐ Continuing Care ☐ Transfer of Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other (explain) _____
I understand by signing below that:	• I may revoke this authorization at any time by notifying the facility listed above. • By signing this form, I am authorizing the release of my protected health information. I understand that upon release this health information is no longer protected and has the potential to be re-disclosed by the recipient • There may be a fee for release of this information and I may be responsible for that fee. • I understand that by signing this form Stellis Health, PA has my written permission to re-disclose medical information that is available in my medical record from another healthcare facility. This information may not be a complete medical record. Stellis Health, PA strongly encourages me to request my medical information from each healthcare facility. No other re-disclosure will be made without my written authorization. • All areas of this form must be completed in order for information to be released. • Treatment will not be denied to me if I do not sign this form. • **Stellis Health, PA shares an electronic medical record with North Memorial Health Center and its affiliates and that information might be included with this consent.** • This authorization expires one year from the date of the signature.
Signature	_____ Patient/Parent/Legal Guardian Signature _____ Date of Signature _____ Relationship if patient unable to sign (must provide proof of Legal right to sign) _____ Reason unable to sign

Directions for Completion of Form

Patient Identity - This is the identifying information of the person whose records are to be released. Complete the entire section. This ensures that the correct patient record will be selected.

Who is releasing - Identify the name of the clinic, hospital, or other health care facility that has the information that you want released.

Who is receiving - This section must be completely filled in with the name and address of whomever is to receive the information. The requested information will be mailed. Typically we do not fax records unless it is a medical emergency. Arrangements can be made if you would like to pick up your records. Contact staff in the HIM department. *Please allow 7 to 10 business days to process your request.*

What is to be released - This section gives us the instructions for what information you want released. Be as specific as you can. If selecting all records, we will release the last 2 years of medical information. Sensitive information does require your very specific consent. This form will be returned to you if this section is not filled in.

Reason for Disclosure - HIPAA requires that the patient indicates why the records are being released.

I understand by signing below - Read this section carefully. This is the information you need in order to make an informed consent to release your records.

Signature - A patient age 18 or older must sign and date this form. Either parent can sign for minor children as long as they state they are the parent. Legal guardians and/or Power of Attorney may sign this release but MUST provide proof of legal right to sign this document.

How to Submit Your Completed Form

Use one of the following methods to submit your completed form to Stellis Health:

- **Email** to: medical.records@StellisHealth.com
- **Mail or drop off** at either of our Stellis Health clinic locations (addresses below)
- **Fax** to 763.581.9090, attention Medical Records