TWIN CITIES PHYSICIANS
Onsite Primary Care

1415 Lilac Drive North, Suite 190 • Minneapolis, MN 55422
PHONE: 763-267-8701
FAX: 763-231-9602

New Patient Forms

Patient Name: _____
First Middle Initial Last

Primary Patient Phone Number: (_____)_____

Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____

Community Name: _____

Circle One: Independent Living Assisted Living Skilled Nursing

Billing Address:_____

City: _____ State: _____ Zip: _____

Room #:_____

Please fax/email the following:

- **Insurance Cards - Copies**
- **Power of Attorney- Healthcare and/or Financial**
- **Records from Most Recent Hospital Stay** (if applicable)

By signing this form, I (or my designee) acknowledge and provide consent for Twin Cities Physicians to provide primary care services, including obtaining outside medical records for continuity of care. I acknowledge that I, or my designee, will promptly follow up with the Twin Cities Physicians team regarding any questions/concerns.

Patient or POA Signature: _____

When completed please send information to:

Fax: 763-312-1800 or **Email**: newadmit@mytcp.org

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Patient Information Sheet

Patient Name: _____
First Middle Initial Last

Emergency Contact / Power of Attorney-Healthcare Information

Name_____ **Phone:** (_____)_____

Relationship to Patient: _____

Previous Primary Care Provider

Provider Name/Clinic:_____

Phone: (_____)_____ **Fax: (_____)_____**

Date of last visit with Previous Primary Care Provider:_____

Additional information you wish to share with your new Twin Cities Physicians provider (optional)**:**

_____
_____
_____
_____
_____
_____
_____
_____

Attention Community: Please update the patient's records to list Dr. Clemencia Rasquinha as the patient's

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Primary Care Provider

Patient Name: _____
First Middle Initial Last

Patient's Current Prescription Medications

Medication & Dosage	How often you take medication

Patient's Current Over-the-Counter Medications/Vitamins

Over-the-Counter Medication/Vitamin & Dosage	How often you take the Over-the-Counter Medication/Vitamin

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Patient Name: _____
First Middle Initial Last

Known Allergies:

_____

_____

Past & Present medical concerns, including any procedures or hospitalizations:

_____

_____

_____

_____

_____

Family Medical History:

Father_____

Mother_____

Siblings_____

_____

_____

Children_____

_____

_____

Social History:

Marital Status: (Circle one) **Single** **Married** **Divorced** **Widowed**

Occupation:_____

Have you ever used tobacco products: ☐ **Yes** ☐ **No**

Frequency of usage/Packs per day: _____ **Quit Date** (If applicable): _____

Do you consume any alcohol: ☐ **Yes** ☐ **No** **Frequency:** (Circle One) **Daily** **Weekly** **Monthly**

Alcoholic drinks consumed in one sitting: (Circle one) | 1 | 2 | 3 | 4 | 5-7 | 8-11 | 12-17 | 18-23 | 24-35 | 36+ |

Any other Drug Use: _____

_____

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Primary care provider	Limited coverage, out of network, etc.	Copay, deductible, etc. as determined by carrier.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

TWIN CITIES PHYSICIANS
Onsite Primary Care

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Procedures authorizing if medically indicated: Wound Care/Wound Debridement, telehealth.

Signature of Patient/Legal Guardian/POA:

_____ DATE:_____

Signature of Witness:

_____ DATE:_____

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Chronic Care Management Services

Chronic Care Management (CCM) is a service provided to Medicare recipients with 2 or more serious chronic conditions that allows Twin Cities Physicians / Midwest Geriatric Services to assist in your comprehensive plan of care related to your health problems and goals. That plan of care ties together the providers you see, the medications you take, all within the community or environment you live in.

Twin Cities Physicians / Midwest Geriatrics Services prides itself on the quality of service we can provide with CCM since it is the mainstay of Care Coordination. It minimizes risk of errors during transitions of care and throughout the continuum of your care.

The services available through our chronic care management program includes:

- Managing ongoing health conditions, checking in with you on your health care needs, making appointments for preventive care, and discussing your medications.
- Being able to get a hold of your care team 24-hours-a-day, 7-days-a-week.
- See a regular provider or care team, whenever possible.
- Coordinating the best care for your health issues include the specialists you see, the hospital systems you access and the emergency care you receive

Your consent is required to participate in Chronic Care Management and as a Medicare recipient you can also rescind this consent at any time. Your consent allows Twin Cities Physicians / Midwest Geriatrics to not only provide the services described above but also share this Coordinated Care with other providers delivering care to you. Your Supplement insurance, copays, and deductibles apply to chronic care management services.

Patient or Guardian (if applicable) _____

Signature: _____ Date: _____

Twin Cities Physicians PC & Midwest Geriatrics
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Twin Cities Physicians PC-Midwest Geratric Services (TCP-MGS), its affiliates and its employees. TCP-MGS will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by TCP-MGS. We are required to notify you in the event of a breach of your unsecured protected health information.

We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address shown at the bottom of this notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated Power of Attorneys or Guardians who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Electronic Communication: During the course of "normal communications" we may email PHI (protected health information) "unencrypted" to the patient or POA once all of the proper forms are filled out. Our company email is HIPAA compliant. If you have provided an email to our organization, we assume that you are giving permission for our practice to email PHI to the email('s) you have provided. We also assume that "email" is the preferred method of communication. If the use of unencrypted email is unacceptable to a patient or POA who requests confidential communications, other means of communicating with the patient (such as by more secure electronic methods or by mail or telephone) will be offered and accommodated. To receive communications in a more secure manner (mail, voicemail, encrypted email, portal access), you must request to opt out of "normal communications" mode. Your profile within our practice will be tagged to communicate only through a "secured communications" means identified and acceptable by the patient or POA. The request to opt out of "normal communication" and into "secured communication" must be in writing and sent to the Privacy Officer. To initiate this method of communications, please call 763-267-8701 and ask for our Privacy Officer.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;

○ If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
○ To workers' compensation agencies for workers' compensation benefit determination.

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DISCLOSURES REQUIRING AUTHORIZATION:
Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.
Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value. Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

○ Public health activities;
○ Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
○ Treatment and payment purposes;
○ Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
○ Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
○ Providing you with a copy of your health information or an accounting of disclosures;
○ Disclosures required by law;
○ Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we

receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or

- Any other exceptions allowed by the Department of Health and Human Services.

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RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" by calling the Privacy Officer at (763) 267-8701. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" by calling the Privacy Officer at (763) 267-8701.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your legal representative. "Accounting Request
Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care

item or service for which you, or someone other than the health plan on your behalf, has paid TCP-MGS in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address shown at the bottom of this notice.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. There will be no retaliation for filing a complaint.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the TCP-MGS Privacy Officer by phone at (763) 267-8701 or at the following address: 1415 Lilac Drive North Suite 210 Golden Valley, MN 55422

This Notice of Privacy Practices is also available on our Twin Cities Physicians web page at www.mytcp.org

Acknowledgement of Receipt of Privacy Practices

_____

Print Patient's Name

_____ _____

Signature of Patient/POA/Guardian Date

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might 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 the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

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

The following are instructions for each section. Please type or print as clearly and 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 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.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state 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 chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place 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 line 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:  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 receives 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 kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

THE GREAT SEAL OF THE STATE OF MINNESOTA L'ETOILE DU NORD 1858

AUGUST2015

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (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 health information be released from at least one of the following:

Organization(s) name _____

Specific health care 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 name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ 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 in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

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

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on 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, 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 will 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 indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.