Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Instructions for the Minnesota Standard Consent to Release Protected 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 protected 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. This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in July, 2014. 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 protected 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 protected 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 protected 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 protected 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 protected health information from all of your health care providers to be released.

4. Indicate where you would like the requested protected health information sent. It is best to provide a complete mailing address as not everyone will fax protected health information. A place has been provided to indicate a deadline for providing the protected health information. **Providing a date is optional.**

5. Indicate what protected health information you want sent. If you want to limit the protected 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 protected health information.

   This helps prevent others from changing your form.

   EXAMPLE:  All protected health information

   If you select **all protected 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 protected 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 protected health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of protected 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 protected 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. Protected 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 protected health information, you need to indicate that in this section.

7. Please indicate the reason for releasing the protected 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 protected 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.

Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Consent to Release Protected Health Information (Page 1 of 2)

1 Patient/Client Information

First Name _____ Middle Name _____ Last Name _____
Patient/Client Date of Birth____/____/ _____ Previous Name(s) _____
Home Address _____
City State _____ Zip Code_____
Daytime Phone _____ Email Address (optional) _____
Medical Record/Patient ID Number (optional) _____

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

I give 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: Email Address (optional) _____

3 I am requesting protected 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 protected health information be sent to:

Organization(s) Name _____
And/Or Person: First Name_____ Last Name _____
Mailing Address _____
City _____ State_____ Zip Code _____
Daytime Phone _____ Fax (optional) _____
Information Needed by (date)____/____/_____(optional)

5 Information to be released

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

☐ Specific Dates/Years of Treatment _____

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

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

☐ History/Physical	☐ Medications	☐ Progress Notes
☐ Treatment Summary	☐ Psychological Evaluation	☐ Care Plan/Treatment Plan
☐ Emergency Room Report	☐ Discharge Summary	☐ Periodic Progress Reports

☐ Other Information or Instructions _____

The following information requires special consent by law. Even if you indicate **all protected 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)

Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield
925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Patient/Client Name_____

6 Protected Health Information incudes 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 protected 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 protected health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing protected health information

☐ Patient's Request
☐ Treatment/Continued Care
☐ Payment
☐ Periodically reviewing treatment progress
☐ Other (please explain) _____
☐ Legal
☐ Coordination of Care
☐ Completing an evaluation for psychotherapy

8

I understand that by signing this form, I am requesting that the protected 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 protected health information based on my consent, my request to stop will not work for that protected health information.

I understand that when the protected 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 _____

9 Patient/Client Signature _____ Date___/___/ _____

Or Legally Authorized Representative's Signature _____ Date___/___/ _____

Representative's Relationship to Patient (Parent, Guardiean, Etc)_____