HealtEast
*Care System*

**HealthEast Hospitals Release of Information Services**
**University Park Medical Building Suite 180**
**1690 University Ave W**
**St Paul, MN 55104 Phone: 651-232-4999 Fax: 651-232-4887**

☐ **I Hereby Authorize HealthEast**

☐ Bethesda Hospital
559 Capital Blvd St. Paul, MN 55103

☐ St John's Hospital
1575 Beam Ave Maplewood, MN 55109

☐ St. Joseph's Hospital
45 West 10th St. St. Paul, MN 55102

☐ Woodwinds Health Campus
1925 Woodwinds Dr. Woodbury, MN 55125

☐ Midway Surgery Center
1700 University Ave St Paul, MN 55104

☐ Midway Pain Center
1700 University Ave St Paul, MN 55104

☐ HealthEast Medical Imaging
3640 Talmage Circle Ste. 100, Vadnais Heights MN 55434
Phone: 651-471-8000 Fax: 651-471-8080

☐ Other _____

**TO REQUEST information FROM:** _____

*Facility name and address →* _____

**Send requested information to:**
**Location**:_____Attn:_____ Fax #_____
*Faxing for patient care needs only

☐ **I Hereby Authorize HealthEast** _____**to RELEASE information TO:**
**(Select from above)**

Name_____ Phone #_____

Address_____

**Regarding the Following Patient:**

Patient Name_____ Phone #_____

Other Names_____ Date of Birth_____

Address_____

**Records to be released:** Date(s) treatment was received: _____

☐ Consultation Report
☐ Discharge Summary
☐ Emergency Room Report
☐ History and Physical
☐ Laboratory Report
☐ Operative Report
☐ Pathology Report
☐ Radiology Image Film
☐ Radiology
☐ Test Results
☐ Photographs, Videos, Digital or Other Images
☐ Other_____

I authorize the release of information relating to: ☐ HIV/AIDS Testing/Treatment
☐ Psychiatric Evaluation/Treatment ☐ Alcohol/Drug Abuse Evaluation/Treatment ☐ Genetic Testing/Evaluation

**Purpose of Release:**
☐ Continuing/Transfer of Care ☐ Insurance ☐ Litigation ☐ Personal Use ☐ Other_____

**This authorization expires on the following date, event or condition**: _____.
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

**Statement of Authorization:**

- I understand that, except for research related treatment, HealthEast will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Management (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____ _____
Relationship to Patient Reason Patient Unable to Sign

_____ _____
Signature of Witness (Verbal Authorization Only) Signature of Witness (Verbal Authorization Only)

**----------For HealthEast Use Only----------**

Medical Records Released By: _____ Date: _____ MR#_____
☐ Copies ☐ Review