Fraser
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AUTHORIZATION FOR THE EXCHANGE/RELEASE/ REQUEST OF PROTECTED HEALTH INFORMATION

1. The person whose information may be used, disclosed or exchanged is:

   Name: (First, MI, Last)

   DOB: **Age:**

   Case Number:

2. Purpose of request:

   ☐ Continuing Care / Ongoing Treatment
   ☐ Educational Planning and Service Provision
   ☐ Application for Insurance
   ☐ Evaluation / Assessment Consultation
   ☐ Disability Determination
   ☐ Other

   Describe other:

3. The information may be used, disclosed to, or exchanged with Fraser and the entity specified below:

   Entity is ☐ Configured for electronic exchange
   ☐ Not configured for electronic exchange

   External Exchange Entity:

   Facility/Name: Phone:

   Address: Fax:

   City/State/Zip:

   Email:

4. The information that may be used, disclosed, or exchanged includes **all** records of diagnosis and treatment.

   Consent ☐ **I GIVE CONSENT** for comprehensive protected health information exchange.
   ☐ **I DENY CONSENT** for comprehensive protected health information exchange.
   If a client/ guardian wishes to limit information OR release OR obtain, they should choose “deny consent” and complete applicable sections in the next section.

   Effective date:

   Expires: (expires in one year unless you request an earlier expiration date)

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AUTHORIZATION FOR THE EXCHANGE/RELEASE/ REQUEST OF PROTECTED HEALTH INFORMATION

Consent to Partial Record Set (Exchange / Release / Request)

I GIVE CONSENT to

☐ **Exchange** information with:
(Information for Fraser to **Exchange**)
- ☐ Any/all records
- ☐ Assessment Data
- ☐ Coordination of Services
- ☐ Discharge Summary
- ☐ Evaluation and/or Progress Reports
- ☐ Family Information
- ☐ Immunization Records
- ☐ Individual Education Plans
- ☐ Lab work
- ☐ Medical History/Clinic visit notes
- ☐ Medication History
- ☐ Psychological/Standardized Testing
- ☐ Therapy Authorization
- ☐ Transportation Authorizations
- ☐ Communication (verbal/written)
- ☐ Other:
  (specify) _____

☐ **Release** information to
(Information for Fraser to Release)
- ☐ Any/all records
- ☐ Coord. of Service/Support Plan
- ☐ Fraser Consultation Reports
- ☐ Fraser Enrollment/Discharge
- ☐ Fraser Evaluation Reports
- ☐ Fraser Family Information/Update
- ☐ Fraser Medication History
- ☐ Communication (verbal/written)
- ☐ Other:
- ☐ (specify) _____

☐ **Request** information from
(Information for Fraser to **Request**)
- ☐ Any/all records
- ☐ Assessment Data
- ☐ Coordination of Services
- ☐ Discharge Summary
- ☐ Evaluation and/or Progress Reports
- ☐ Family Information
- ☐ Immunization Records
- ☐ Individual Education Plans
- ☐ Lab work
- ☐ Medical History/Clinic visit notes
- ☐ Medication History
- ☐ Psychological/Standardized Testing
- ☐ Therapy Authorization
- ☐ Transportation Authorizations
- ☐ Communication (verbal/written)
- ☐ Other:
  (specify) _____

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MY OCCUPATIONAL PROFILE

I understand that my records are protected under State and Federal confidentiality and data privacy regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information exchanged is limited to staff whose work assignments reasonably require access to my data within the purpose specified in the services provided.

Fraser cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is release. ,By signing this authorization, you release Fraser from liability resulting from a re-disclosure by the recipient.

Fraser will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I do not have to consent to the release of this information; however, I understand that not doing so may affect this program's ability to provide needed services to me.

I understand this authorization expires (1) year from my signature date, and may include past and future documentation generated through the expiration date. This can be revoked at any time by written request to the Fraser Health Information Management (HIM) Department.

Signature of client **Date**

Signature of client's representative(s) (if applicable) **Date**

PRINT name of client's representative **Relationship**

Please return completed form, attention:

- ☐ Fraser Health Information Management, 2400 West 64th Street, Richfield, MN 55423 Phone: 952-737-6205, Fax: 612-728-5301
- ☐ Fraser Home & Community Supports/Supervised Living, 1801 American Boulevard East, Suite 6, Bloomington, MN 55425 612-767-5180, Fax: 612-767-5176
- ☐ Fraser School, 2400 W 64th Street, Minneapolis, MN 55423, Fax 612-861-6050

Fraser clinical staff: Please place signed, completed document in clinical "To Be Scanned" folder. Do not interoffice the signed document yourself.