FRASER

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AUTHORIZATION FOR THE EXCHANGE/RELEASE/REQUEST OF INFORMATION

Client Name | DOB | Case/Medical Record Number

I/We, the undersigned, hereby authorize **Fraser** to: *(check one)*

☐ **Exchange Information:** (Release and Request)
☐ **Release To:** (Only Send Information)
☐ **Requested From:** (Only Obtain Information)

Agency | Attention

Phone | Fax

Address

City | State | Zip

Email

Purpose: *If left blank, Fraser will assume the purpose is for continuity of care.*

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

Document Types

Information to be **Exchanged** (both released and requested)	Information to be **Released** (from Fraser)	Information to be **Requested** (by Fraser)
☐ Any/all records	☐ Any/all records	☐ Any/all records
☐ Evaluation or Assessment Consultation	☐ Evaluation or Assessment Consultation	☐ Evaluation or Assessment Consultation
☐ Health/Clinical Records	☐ Health/Clinical Records	☐ Health/Clinical Records
☐ Communication (verbal/written)	☐ Discharge Summary	☐ Psychological Testing
☐ Transportation Authorization	☐ Communication (verbal/written)	☐ Individual Education Plans (IEPs)
☐ Other (specify):	☐ Transportation Authorization	☐ Communication (verbal/written)
	☐ Other (specify):	☐ Transportation Authorization
		☐ Other (specify):
Date Range _____		

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Client Name | DOB | Case/Medical Record Number

Method of Release: *If left blank, Fraser will send the identified information in the most secure way possible, or the method previously requested by client/guardian.*

- ☐ **Any/all**
- ☐ Fax
- ☐ Secure Email (client/guardian only)
- ☐ US Postal Service
- ☐ Verbal

I/We understand that my/our records are protected under State and Federal confidentiality and data privacy regulations and cannot be disclosed without my/our written consent unless otherwise provided for in the regulations. I/We understand that information exchanged is limited to staff whose work assignments reasonably require access to my/our 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 released. 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/We 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 the client/guardian.

I/We understand this authorization expires one year from my/our signature date and may include documentation generated after the signature date up until the expiration date of this release. 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 legal representative** | Date

PRINT name of client or client's representative (From whom verbal consent obtained) | Relationship

Witnessed By (Fraser Staff Signature) | Date
Verbal consent provided by client/guardian due to COVID-19 shelter in place

Return Form to: Fraser Health Information Management
2400 West 64th Street
Minneapolis, MN 55423
P) 952-737-6205
F) 612-728-5301