Authorization for Release
of Protected Health Information

Print patient's legal name: Blake Arthur Kell **Birth date:** 10/19/2003

Other names used: _____ Day Phone: 612 450 0720

Patient address: 1600 Grand Ave St Paul Minnesota

1. **Please release my records from:** *(Who has your records? Please name the hospitals and/or clinics below. For example: Fairview, HealthEast, University of Minnesota Physicians Clinic (UMP) or other organizations.)*
   Name: Smileys Phone: 612 333 0770 Fax: 612 333 1986
   Address: 2020 E 28th St City: Minneapolis State: Minnes Zip: 55105

2. **A. Release records for this health issue or treatment date(s):** 7/21/2025
   (If you leave the line above blank, we'll release 1 year's worth of your most recent records.)
   ☐ Related (pertinent) hospital and clinic records (notes, test results, medicines) ☐ Vaccines
   ☐ Radiology reports ☐ Lab/Pathology reports ☐ EKG/echo reports ☐ Health maintenance records
   ☐ X-ray/radiology images ☐ Emergency/Urgent Care ☐ History & physical ☐ Billing information
   ☒ Other (which ones?): CT scan
   B. We'll release **all** records for mental health, addiction, and AIDS/HIV-related illness, testing, and treatment for the dates above unless you tell us **not** to release those records. **Please list any records you *don't* want us to release:**
   _____

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: Midwest Ear NOse & Throat Phone: 651 641 6134 Fax: 651 501 5321
   Address: 3460 Promenade Ave City: Eagen State: Minnes Zip: 55105

4. **Deliver with:** ☐MyChart (patient portal) ☐ US mail ☐ CD ☐ E-mail (address: _____)
   ☒ Fax (only for continuing care) ☐ Will pick up (by appointment only) **Date needed by:** _____

5. **To be used for:** ☒ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ _____

6. **I understand that:**
   - If I change my mind, I can write to the address I listed under number **1** above and tell them to stop releasing my records. This **won't** take back any records that have already been released.
   - After the records are released, the place that released my records **can't** stop them from being shared with someone else. At that point, state and federal privacy laws may no longer protect my records.
   - If my records include information that you got from other places, this information may be released along with the rest of my records.
   - You may release records of my **future visits**, starting on the date I sign this form and ending on: 12/25/2025 (date).
   - I may have to pay a fee for releasing these records.
   - A copy of this completed, signed form is OK (valid) as long as it's **not** changed after signing.
   - I understand that signing this form won't affect my treatment, payment, enrollment, or benefits, unless the treatment is used for research.
   - This form expires 1 year after I sign it, or on 12/25/2025, unless the law says otherwise.

7/18/2025	3:47 PM	Blake Kell	
Date	**Time**	**Patient or authorized person sign here**	**If you're *not* the patient, print your name and why you can sign for the patient. (We may need proof)**

If you used an interpreter, please fill in the information below:

_____ _____ / _____ _____ _____

Interpreter name (if used) *Language/Organization* *Date* *Time*

Directions for the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Please print. Please note that blank items on this form may cause major delays in processing your request. Complete this form as fully as possible. Allow at least 10 business days for processing.

Top - Patient Information: This is about the patient. Please fill it out completely.

1. Release records from: Write down which clinic, hospital, or other place has the medical records.

2A. Release records for this health issue or treatment date(s): Check or write out which records you want released. Mark the box next to what you want released. Check "other" to request any records not listed. Please write which records you need.

2B. Please list any records you *don't* want us to release: List any records for the dates or health issues you listed above that you **don't** want released.

3. Please release my records to: Write down your name or the name of another person, health care site or organization that needs the medical records. (Please note: it is M Health Fairview's policy NOT to fax or e-mail patient information except for direct patient care needs or by patient request, such as to a hospital or clinic.)

4. Deliver with: Mark how you would like the records to be prepared and delivered. The patient portal offers secure online delivery for patients who have shared their e-mail address.

5. To be used for: Mark why you need a copy of the records. This will help us track your request. It also tells us who should pay if there is a cost for any of the records.

6. I understand that: Read the bullet points. This consent will expire (end) in 12 months unless you write in a different date. You may **stop** or **revoke** (take back) your consent by writing us. Sign and date the form and include the time. If you are signing the document **for** the patient, we may need to see proof of your legal authority. Proof examples: Power Of Attorney (POA) for Healthcare, Advance Care Directive, or court-appointed Legal Guardianship documents

Contact Information for Release of Information:

M Health Fairview
Release of Information: 2450 Riverside Ave, Minneapolis, MN 55454 (**Pickup by appointment only**)
Email: releaseofinformation@fairview.org
Phone: 952-924-5165
Fax to send **requests** for records: 952-915-8824
Fax to send records: 612-884-3667

Fairview Range Medical Center
Health Information Management
750 East 34th Street
Hibbing, MN 55746
Phone: 218-362-6627
Fax: 218-362-6678

Grand Itasca Clinic & Hospital
1601 Golf Course Road
Grand Rapids MN 55744
Phone: 218-326-3401
Fax: 218-999-1513

FIIRO GAAR AH: Hadii aad ku hadasho Soomaali, waaxda luqadaha, qaybta kaalmada adeegyada, waxay idiin hayaan adeeg kharash la'aan ah. So wac 612-273-3780.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-273-3780.

We comply with applicable federal and state civil rights laws, including the Minnesota Human Rights Act. We do not discriminate because of race, color, creed, religion, national origin, marital status, age, disability, sexual orientation or sex.

INFORMATIONAL PAGE ONLY