Member information release form

Request date		
Member name	Member date of birth	Member ID
Member address		
Phone number	Email	

SECTION 1: Information to be released

Hennepin Health or _____ may release

information to:_____
(the name of the entity or person to whom you want the information provided).

(Check the information you want to be released)

- ☐ My name
- ☐ Demographic information
- ☐ Claims
- ☐ Medication
- ☐ Alcohol and drug abuse treatment
- ☐ Care plans
- ☐ HIV/Aids
- ☐ Mental health
- ☐ Genetic testing
- ☐ Utilization review
- ☐ Restricted recipient information
- ☐ Service authorization
- ☐ Appeals and grievances
- ☐ Assessments
- ☐ Enrollment
- ☐ Financial
- ☐ Photographs, video, digital or other images
- ☐ Other, specify_____

The records checked above may be released for the following time period:
_____ (if no specific time period leave blank).

SECTION 2: Reason for the release

(Check all that apply)

- ☐ Member request
- ☐ Research
- ☐ Review member's current care/treatment
- ☐ Insurance
- ☐ Payment
- ☐ Legal
- ☐ Appeal/grievance
- ☐ Continuity of care
- ☐ Media release
- ☐ Marketing
- ☐ Other, specify_____

This release will expire after one year from the date this form is signed unless I specify an earlier date, event or condition here: _____.

SECTION 3

By signing this form:

- I agree that Hennepin Health may use and release information about me indicated in **Section 1** for the reasons checked in **Section 2** above.
- I have the right to cancel this release in writing to Hennepin Health at any time. I understand that information might have already been shared before I canceled the release.
- Any information used or disclosed may no longer be protected by law. It may also have been re-disclosed by the person or entity receiving it.
- I understand that I do not have to sign this release. If I choose not to sign this release, it will not affect my health coverage.
- I understand that the information released about me may let others know that I am covered under a Minnesota health care program.
- I hereby release Hennepin Health from any and all claims arising out of or in connection with the use of the released information.

Member or personal representative signature Date
(Personal representative – please state your relationship to the member)

Return form to:
Hennepin Health
300 S 6th St MC 604
Minneapolis, MN 55487-0604
612-904-4267

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