Hazelden Betty Ford Foundation

How to Obtain Copies of your Medical Records

Please print, ensure all fields are complete, legible, and sign and date the form. Failure to properly complete each field may result in a delay in sending out the requested records.

Patient Identification: Print your complete legal name, any other names you might have used while a patient at Hazelden Betty Ford, and your birth date. It is important you include your telephone number with area code in case we need to contact you about any questions or concerns with your release request.

Preferred Method of Release: Identify how you would like the information to be delivered by checking one (Mail, Fax, or Email.)

Requestor Information: Who should the information be sent to? Per federal privacy regulations, if the requestor is not a healthcare provider, an individual name must be included. It is helpful to also include the agency name as well, if applicable (i.e. John Jones, Jones Law Firm). Be sure to include the contact information depending on how you want the information to be delivered (i.e. physical address for mail, fax number for fax and an email address for email.)

Purpose of Release: Why the information is needed? Per federal privacy regulations we need to know why you are requesting copies of your record so we can ensure that we provide the records to accomplish the intended purpose of the request.

Information Requested: Check the information/records that you want to be disclosed to the requestor.

HIV/AIDS status: As a patient of Hazelden Betty Ford you have the right to choose *NOT* to disclose any information that includes HIV/AIDs status. By selecting, "I do not want this included," our staff will do the best they can to review your medical record prior to releasing any records to ensure that any mention of HIV/AIDs status will not be released. Please note that if HIV/AIDs status is mentioned anywhere in a note/documentation, this includes testing for HIV/AIDs either positive or negative, the entire note will not be released. This could potentially impact insurance reimbursement, disability applications or other requestors if they do not receive the proper documentation. In the event of a medical emergency, our staff may release this information if it is vital for your care.

Patient Signature: We cannot release your records without your signature. We cannot, by law, accept a form with your signature typed in. *You must sign for your own records, even for minors.* Parents, spouses, children, or other individuals may not sign for you.

Date: It is very important to ensure you enter the date that you signed the release. All releases automatically expire one year from the date of your signature.

Return the completed, signed form to the attention of Health Information Department:

Fax: (651) 213-4496
Mail: P.O. Box 11, BC 22, Center City, MN 55012

Fees: There may be a processing fee. Fees depend on the number of pages copied and are assessed in accordance with state and federal regulations.

Authorization to Disclose Medical Records

Patient Name (print):_____ **Birthdate:** _____

Other names used in treatment: _____ **Phone:** _____

Dates of service: _____

How would you like this information sent? _____ Mail _____ Fax ____ Email

I authorize the Hazelden Betty Ford Foundation and Recovery Partners to communicate with and release information to: (*If recipient is not a healthcare provider, an individual name must be included.)

Name: _____ **Attention:** _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

Email Address – Print Clearly: _____

Why the information is needed:

___ Personal ___ Insurance ___ Legal ___ Disability/FMLA ___ Back to Work

___ Verify Attendance ___ Treatment/Continuing Care ___ Other (specify):_____

Check all types of information to be disclosed to above party (copy fee may apply):

___ Medical/Nursing

___ Labs/X-Rays

___ Medications

___ Mental Health

___ Chemical Dependency

___ Discharge Summaries/Notes

___ Treatment Plan

___ Progress Notes/Continuing Care

___ Face sheet/Insurance Information

___ Letter with **Treatment Dates**, also include if marked:

☐ Discharge Status ☐ Recommendations/Plan

___ Records needed for **Insurance Appeal**

___ Records needed for Disability/FMLA

___ Complete Medical Record

___ Other:_____

_____

Information and records requested may include reference to my HIV/AIDS status: ___ I do **NOT** want this included

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Hazelden Betty Ford Foundation (HBFF)'s Privacy Notice.
- I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. HBFF's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)].
- Communications resulting from this authorization will reveal that I received services at HBFF.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires HBFF to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.
- This authorization may be used by HBFF owned or managed programs upon transfer of my care to them.

Patient Signature: _____**Date:** _____

P**arent/Guardian Signature:** _____ **Date:** _____
(when required)

Please send completed forms to:
Health Information Department
15251 Pleasant Valley Rd, PO Box 11, BC 22
Center City, MN 55012-0011
Fax: 651-213-4496
Email: HealthInformation@hazeldenbettyford.org

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