MINNESOTA WellCare

10519 165th Street W
Lakeville, MN 55044
P: 952.248.2720
F: 888.286.9823

Patient Authorization to RELEASE HEALTH INFORMATION

First and Last Name: _____

Date of Birth (MM/DD/YYYY): _____

Home Address (inc. city, state, zip):_____

Phone Number: _____

I am requesting health information be released from the following clinic/organization:

Provider Name: _____

Clinic Name and Address: _____

Clinic Phone: _____

Clinic Fax: _____

I am requesting health information be released to the following clinic/organization:

Minnesota WellCare LLC
10519 165th Street W.
Lakeville, MN 55044
Office Phone: 952.248.2720
Office Fax: 1.888.286.9823

I authorize the release of pertinent medical and psychiatric health information to Minnesota WellCare LLC as outlined below.

Information to be released:

Indicate only the information that you are authorizing to be released:

_____ All Health Records _____ History/Physical _____ Laboratory Reports

_____ Emergency Room _____ Medications _____ Therapy Notes

_____ Psychiatric Notes _____ ADHD Evaluation _____ Hospital Admission

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

I authorize the release of information as pertaining to chemical dependency.

_____ Yes _____ No

Dates of service:

_____ All Dates

Purpose of release:

_____ Continuity of Care _____ Legal _____ Insurance

_____ Disability Determination _____ Personal _____ Other

Health information includes written and oral information:

I authorize written release of my protected health information as outlined above. Please fax pertinent records to Minnesota WellCare LLC at 1-888-286-9823.

_____ Yes _____ No

I understand that by signing this form, I am requesting that the health information be exchanged between the parties specified.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in this form.

If the organization, facility or professional named in this form has already released health information based on my consent, my request to stop will not apply to that information which has already been shared.

I understand that if the organization named is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

I understand that I do not have to sign this form, and my provider at Minnesota WellCare LLC may not limit my care based on my refusal to sign this form.

CLIENT/GUARDIAN SIGNATURE: _____

Guardian name (if applicable): _____

Relationship of signer to client:

_____ Self _____ Mother _____ Father _____ Legal Guardian

Date (MM/DD/YYYY): _____