THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A. AND THE SUBSIDIARIES MCRH ALPHA, P.A. AND GREAT PLANES REPRODUCTIVE CENTERS, P.A.

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

Phone 763.494.7700
Toll Free 800.508.9763
Fax 763.494.7706
Web Site www.mcrh.com

Patient Authorization for Release of Medical Information

The Patient Authorization will give our office the authority to provide the person or entity you and your spouse/partner (if applicable) designate on the form with access to your protected health information (**PHI**). The Patient Authorization is limited to accessing only the information that you and your spouse/partner (if applicable) designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your joint health information to a person or entity that may be involved in your healthcare. Due to the nature of treatment received at MCRH and its subsidiaries, records for patient and spouse/partner will be maintained **jointly** and this Authorization pertains to all medical records regarding patient and spouse/partner (if applicable).

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Directions for Completion of Authorization for Release of Medical Information Form

Patient Information: Please complete the entire section with patient demographic information.

Clinic/Health Provider: This identifies who is to provide the release of Protected Health Information.

Receiving Party: This information identifies a person or entity you and your spouse/partner (if applicable) have authorized the Provider to release your PHI.

Description of Information to be Released: The type and amount of health information that we disclose is determined by you and your spouse/partner (if applicable). We can disclose or provide access to all of your health information or it can be limited to a specific item.

Release Type: This information tells us how you would like your PHI transmitted to a person or entity. Please see our Medical Record Release and Payment policy for more information. If you wish to view your records, please contact MCRH at 800-508-9763 to schedule a medical record review appointment.

Release Purpose: The purpose of your release of PHI is required to be documented by MCRH. This also helps us in determining if a fee is applicable for reproduction of records.

Termination or Expiration: The Authorization will expire at the end of the calendar year of your last signature unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than the end of the calendar year. You have the right to terminate the Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. MCRH may require a signed Authorization on disclosures.

Redisclosure Statement: The practice places no condition to sign the Authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosure under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Signature and Date: Because your medical records are kept jointly at MCRH, both patient and spouse/partner (if applicable) will need to sign and date the Authorization. PHI on both parties will be released unless indicated under Information to be Released.

Copies: We will provide you with a copy of this signed authorization upon request.

The Midwest Center for Reproductive Health, P.A. and its subsidiaries MCRH Alpha, P.A, and Great Planes Reproductive Centers, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION	**Name:** _____ **Date of Birth:**_____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
CLINIC/HOSPITAL/ HEALTH CARE PROVIDER *(Who has the information you want released?)*	☐ Midwest Center for Reproductive Health, P.A. and its subsidiaries **Name:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
RECEIVING PARTY *(Where do you want to information sent or who may have a copy of your PHI per your request?)*	☐ Midwest Center for Reproductive Health, P.A. *OR* ☐ SELF 12000 Elm Creek Blvd N, Suite 350, Maple Grove, MN 55369 Ph: 800-508-9763 Fax: 763-494-7766 *OR* **Name:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
INFORMATION TO BE RELEASED (*What do you want sent or released? Check the applicable box)*	☐ Any and all records (including ALL types of records listed below) ☐ Billing Records ***please review policy for details* ☐ Copies of Films/images ☐ Only records type checked below: **FEMALE:** ☐ Operative report ☐ Biopsy report ☐ Current pap ☐ HSG/Sono reports and films ☐ Post coital results ☐ Rubella ☐ Antisperm antibody results ☐ Blood tests including infectious disease results ☐ Flow sheet from ovulation cycles **MALE:** ☐ Semen analysis results ☐ Antisperm antibody results ☐ Urology-Operative reports
RELEASE INSTRUCTIONS (How and when do you want the information?)	Date Information is Needed: _____ ***please allow 7-10 business days for processing* ***please review policy for details* Release Method/Format Request: (check ONE) ☐ Paper ☐ CD/DVD (patient only) ☐ View my records ☐ Fax (facility only)
PURPOSE OF RELEASE (***Why** this is needed?)*	☐ Continuing care ☐ Transfer of care ☐ Insurance application ☐ Personal use or review ☐ Insurance payment/claim ☐ Litigation/Legal ☐ Other: _____ ***applicable fees may apply to releases*

- This Authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this Authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosure under this Authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.
- Your signature indicated your authorization to release your PHI as described above.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
SPOUSE / PARTNER / GUARDIAN SIGNATURE **DATE** *Copies of signed authorizations are available upon request.*

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Medical Record Release and Payment Policy

Due to the nature of treatment received at MCRH and its subsidiaries, records for patient and spouse/partner (if applicable) will be maintained **jointly** and the Authorization pertains to all medical records regarding patient and spouse/partner (if applicable). Our policies are designed around Federal and State laws. We will make every reasonable effort to produce the record in a timely fashion.

Patient's "original" health records are the property of the facility and are not to be removed from the facility. Patients have a right to review and receive **copies** of their medical records per state and federal law. Records generated from another medical facility may be released to the **patient** only. The validity and completeness of outside facility records cannot be guaranteed by MCRH. MCRH will accept a photo copy or original of a signed Authorization for Release of Medical Records.

Where is the info being disclosed	Records that will be disclosed	Form Needed for Disclosure	How will we release the records	Applicable Fee
Patient and spouse/partner	All records including those from other facilities	Current Registration form or Authorization form	Paper copy or CD that can be mailed or picked up by patient	**please see applicable fee policy below
Other facility	MCRH records only	Authorization form for each release	Paper copy via mail or fax	
Referring physician	MCRH records only	Current Registration form or Authorization form for each release	Paper copy via mail or fax	Free during current treatment, then applicable fee policy—see below
Health Insurance Company	MCRH records only	Current Registration form or Authorization form for each release	Paper copy via mail or fax	Free during current treatment process for claim purposes, then applicable fee policy—see below
Insurance Application, etc.	MCRH records only	Authorization form for each release	Paper copy via mail or fax	Full price for records—see below
Litigation/Legal	MCRH records only	Authorization form for each release	Paper copy via mail or fax	Full price for records—see below

Applicable Fees

Patient and spouse/partner, other facilities, referring physicians, and health insurance company:
MCRH recommends having a complete set of your joint medical records released to the patient to maintain and disperse as needed.

Treatment Time and Release	Applicable Fee
1st set of copies if treatment has occurred in the last 3 years	Free
Additional copies if treatment has occurred in the last 3 years	$20.00 plus applicable taxes per calendar year
Any copies if treatment occurred more than 3 years ago	Full price per calendar year in accordance with Minnesota Statute 144.292 and Federal Rule 45 CFR §164.524
For records to the patient via CD if treatment has occurred in the last 3 years	$20.00 plus applicable taxes per calendar year
For records to the patient via CD if treatment occurred more than 3 years ago	Full price per calendar year in accordance with Minnesota Statute 144.292 and Federal Rule 45 CFR §164.524