FRASER
Authorization for the Exchange/Release/Request of Protected Health Information

1. The person whose information may be used, disclosed or exchanged is:
   Name: (First, MI, Last) _____ _____ _____
   DOB: _____ **Age:** _____
   Case Number: _____

2. Purpose of request:
   ☐ Continuing Care / Ongoing Treatment
   ☐ Educational Planning and Service Provision
   ☐ Application for Insurance
   ☐ Evaluation / Assessment Consultation
   ☐ Disability Determination
   ☐ Other
   Describe other: _____

3. The information may be used, disclosed to, or exchanged with Fraser and the entity specified below:
   Entity is ☐ Configured for electronic exchange
   ☒ Not configured for electronic exchange

   External Exchange Entity:
   Facility/Name: _____ Phone: _____
   Address: _____ Fax: _____
   City/State/Zip: _____ _____ _____
   Email: _____

4. The information that may be used, disclosed, or exchanged includes **all** records of diagnosis and treatment.
   Consent ☐ **I GIVE CONSENT** for comprehensive protected health information exchange.
   ☐ **I DENY CONSENT** for comprehensive protected health information exchange. *If a client/guardian wishes to limit information OR release OR obtain, they should choose "deny consent" and complete applicable sections in the next section.*

   Effective date: _____
   Expires: _____ (expires in one year unless you request an earlier expiration date)

Consent to Partial Record Set (Exchange / Release / Request)
I GIVE CONSENT to

☐ **Exchange** information with: (Information for Fraser to **Exchange**)	☐ **Release** information to (Information for Fraser to **Release**)	☐ **Request** information from (Information for Fraser **to Request**)
☐ Any/all records	☐ Any/all records	☐ Any/all records
☐ Assessment Data	☐ Coord. of Service/Support Plan	☐ Assessment Data
☐ Coordination of Services	☐ Fraser Consultation Reports	☐ Coordination of Services
☐ Discharge Summary	☐ Fraser Enrollment/Discharge	☐ Discharge Summary
☐ Evaluation and/or Progress Reports	☐ Fraser Evaluation Reports	☐ Evaluation and/or Progress Reports
☐ Family Information	☐ Fraser Family Information/Update	☐ Family Information
☐ Immunization Records	☐ Fraser Medication History	☐ Immunization Records
☐ Individual Education Plans	☐ Communication (verbal/written)	☐ Individual Education Plans
☐ Lab work	☐ Other: (specify) _____	☐ Lab work
☐ Medical History/Clinic visit notes		☐ Medical History/Clinic visit notes
☐ Medication History		☐ Medication History
☐ Psychological/Standardized Testing		☐ Psychological/Standardized Testing
☐ Therapy Authorization		☐ Therapy Authorization
☐ Transportation Authorizations		☐ Transportation Authorizations
☐ Communication (verbal/written)		☐ Communication (verbal/written)
☐ Other: (specify) _____		☐ Other: (specify) _____

FRASER
Special needs ★ Bright futures®

Name: (First, MI, Last) _____ **Date of Birth:** _____ **Case Number** _____

I understand that my records are protected under State and Federal confidentiality and data privacy regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information exchanged is limited to staff whose work assignments reasonably require access to my data within the purpose specified in the services provided.

Fraser cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is release. By signing this authorization, you release Fraser from liability resulting from a re-disclosure by the recipient.

Fraser will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I do not have to consent to the release of this information; however, I understand that not doing so may affect this program's ability to provide needed services to me.

I understand this authorization expires (1) year from my signature date, and may include past and future documentation generated through the expiration date. This can be revoked at any time by written request to the Fraser Health Information Management (HIM) Department.

Signature of client	**Date**
Signature of client's representative(s) (if applicable)	**Date**
PRINT name of client's representative	**Relationship**

Please return completed form, attention: _____

☐ Fraser Health Information Management, 2400 West 64th Street, Richfield, MN 55423 Phone: 952-737-6205, Fax: 612-728-5301
☐ Fraser Home & Community Supports/Supervised Living, 1801 American Boulevard East, Suite 6, Bloomington, MN 55425 612-767-5180, Fax: 612-767-5176
☐ Fraser School, 2400 W 64th Street, Minneapolis, MN 55423, Fax 612-861-6050

Fraser clinical staff: Please place signed, completed document in clinical "To Be Scanned" folder. Do not interoffice the signed document yourself.