

Authorization for Release of Private Health Information

Patient:

Name _____ Birth Date _____
Address _____ City _____
State _____ Zip Code _____
Date of Injury _____ Date(s) of Treatment _____

Information to be Released to:

Office of the Minneapolis City Attorney
333 S. 7th Street, Suite 300
Minneapolis, MN 55402

Phone: 612-673-2010
Fax: 612-673-2189

Custodian of Records:

Hospital _____
Address _____ Telephone _____

Information to be Released:

All certified / uncertified

Medical records pertaining to the above-referenced incident date treatment date(s), including but not limited to:

x-ray/radiology reports photographs
 discharge summary operative reports
 ER reports consultation reports other

Purpose: This information is needed for the following Purpose: Use in the investigation and prosecution of the case(s)

State of Minnesota v _____

Case Number(s) _____

1. This authorization will automatically expire one year from the date of my signature.
2. This authorization may be revoked by written request of the patient at any time to the address listed for the requesting entity. A revocation will not apply to information that has already been released in response to this authorization.
3. Once information is released pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rule, 45 CFR Parts 160 and 164.
4. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____. Please indicate any restrictions: (Specify) _____.
5. This authorization must be filled out completely and signed and dated to be considered valid.
6. A copy of this authorization will be considered as valid as the original authorization.
7. Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon signing of this authorization form.

Patient's /Authorized Person's Signature:

Signature of Patient/Authorized Person _____ Date _____

Authorized Person's Authority to Sign _____

Reason Patient is unable to sign: Minor Deceased Other _____

MP-9037 Rev. 4/08

PLEASE BE SURE SHADED AREAS ARE COMPLETED BEFORE HAVING RELEASE SIGNED.

Authorization for Release of Private Health Information
Autorización Para Divulgar La Información Privada Sobre Su Salud

Patient/Paciente:
Name/Nombre _____ **Birth Date/Fecha de Nacimiento** _____
Address/Domicilio _____ **City/Ciudad** _____
State/Estado _____ **Zip Code/Código Postal** _____
Date of Injury/Fecha en que ocurrió la Lesión _____ **Date(s) of Treatment/Fecha(s) que recibió tratamiento** _____

Information to be Released to/Información será divulgada a:
Office of the Minneapolis City Attorney /La Oficina del Procurador de la Ciudad de Minneapolis
333 S. 7th Street, Suite 300 **Phone: 612-673-2010**
Minneapolis, MN 55402 **Fax: 612-673-2189**

Custodian of Records/Conservador de Registros:
Hospital/Clínica _____
Address/Dirección _____ **Telephone/Teléfono** _____

<p>Information to be Released: All <input checked="" type="checkbox"/> certified / <input checked="" type="checkbox"/> uncertified Medical records pertaining to the above-referenced incident date treatment date(s), including but not limited to: <input checked="" type="checkbox"/> x-ray/radiology reports <input checked="" type="checkbox"/> photographs <input checked="" type="checkbox"/> discharge summary <input checked="" type="checkbox"/> operative reports <input checked="" type="checkbox"/> ER reports <input checked="" type="checkbox"/> consultation reports <input checked="" type="checkbox"/> other</p>	<p>Información que será divulgada: Todos los expedientes médicos <input checked="" type="checkbox"/> certificados / <input checked="" type="checkbox"/> sin certificación Correspondiente a la fecha del incidente arriba Indicado y las fechas de tratamiento, incluyendo, pero no limitados a: <input checked="" type="checkbox"/> reportes de Rayos X/Radiografía <input checked="" type="checkbox"/> fotografías <input checked="" type="checkbox"/> Informe/Resumen de Alta <input checked="" type="checkbox"/> reportes de cirugías <input checked="" type="checkbox"/> reportes de sala de emergencia <input checked="" type="checkbox"/> reportes de consultas <input checked="" type="checkbox"/> otro</p>
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Purpose: This information is needed for the following Purpose: Use in the investigation and prosecution of the case(s):
Propósito: Esta información se necesita por el siguiente propósito: Uso en la investigación y juicio del caso(s):
State of Minnesota v/El Estado de Minnesota v _____
Case Number(s) /Número de Caso(s) _____

- | | |
|--|---|
| <p>8. This authorization will automatically expire one year from the date of my signature.</p> <p>9. This authorization may be revoked by written request of the patient at any time to the address listed for the requesting entity. A revocation will not apply to information that has already been released in response to this authorization.</p> <p>10. Once information is released pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rule, 45 CFR Parts 160 and 164.</p> <p>11. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____. Please indicate any restrictions: (Specify)_____.</p> <p>12. This authorization must be filled out completely and signed and dated to be considered valid.</p> <p>13. A copy of this authorization will be considered as valid as the original authorization.</p> <p>14. Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon signing of this authorization form.</p> | <p>1. La autorización expirará automáticamente un año después de la fecha de mi firma.</p> <p>2. Esta autorización puede ser revocada en cualquier momento con una solicitud escrita por el paciente a la dirección indicada por la entidad solicitando la misma. Una revocación no será aplicada a la información cual ya fue proveída en respuesta a esta autorización.</p> <p>3. Una vez la información es proveída de acuerdo con ésta autorización, la información puede ser sujeta a nueva divulgación por el recipiente y puede que ya no sea protegida por la regla federal de la privacidad, 45 CFR Partes 160 y 164.</p> <p>4. Con la excepción a las notas de psicoterapia, todos los registros correspondientes a la salud mental o psiquiatra, dependencia química y/o relacionada a la enfermedad o la prueba de SIDA/VIH será proveída tan solo que lo contrario sea indicado marcando aquí: _____. Favor de indicar cualquier restricción:(especifique)_____.</p> <p>5. Esta autorización debe de ser completada enteramente y firmada y fechada para que pueda ser considerada válida.</p> <p>6. Una copia de esta autorización será considerada como válida tal como la autorización original.</p> <p>7. El tratamiento, pago de servicios, matriculación y elegibilidad para beneficios no dependen en que se firme este formulario de autorización.</p> |
|--|---|

Patient's /Authorized Person's Signature: Firma del Paciente/la persona Autorizada:
Signature of Patient/Authorized Person/ _____ **Date/Fecha** _____
Firma del Paciente/Persona Autorizada
Authorized Person's Authority to Sign/Autoridad de la Persona Autorizada a firmar _____
Reason Patient is unable to sign/Razón por la cual la persona no puede firmar: Minor/Menor de edad Deceased/Fallecido(a) Other/Otra _____
 MP-9040 Rev. 4/08

PLEASE BE SURE SHADED AREAS ARE COMPLETED BEFORING HAVING RELEASE SIGNED.

Authorization for Release of Private Health Information
Oggolaanshaha Bixinta Warbixinta Caafimaadka Sirta

Patient/Bukaan:	
Name/Magaca _____	Birth Date/Taariikhda Dhalashada _____
Address/Cinwaanka _____	City/Magaalada _____
State/Gobolka _____	Zip Code _____
Date of Injury/Taariikhda shilka _____	Date(s) of Treatment/Tariikhda Daawada _____
Information to be Released to/Warbixinta La Siinayo:	
Office of the Minneapolis City Attorney/Xafiiska Qareenka Magaalada Minneapolis 333 S. 7th Street, Suite 300 Phone: 612-673-2010 Minneapolis, MN 55402 Fax: 612-673-2189	
Custodian of Records/Masuulka Diiwaanka:	
Hospital/Doctor / Dhakhtarka/Cisbitaalka _____	
Address/Cinwaanka _____	Telephone/Telefoonka _____
Information to be Released: All <input checked="" type="checkbox"/> certified / <input checked="" type="checkbox"/> uncertified Medical records pertaining to the above-referenced incident date treatment date(s), including but not limited to: <input checked="" type="checkbox"/> x-ray/radiology reports <input checked="" type="checkbox"/> photographs <input checked="" type="checkbox"/> discharge summary <input checked="" type="checkbox"/> operative reports <input checked="" type="checkbox"/> ER reports <input checked="" type="checkbox"/> consultation reports <input checked="" type="checkbox"/> other	Warbixinta La Soo Saarayo: Dhamaan <input checked="" type="checkbox"/> Diiwaanka caafimaadka ee Hubaalka / <input checked="" type="checkbox"/> Aan hubaalka ahayan oo khuseysa dhacdada taariikhda iyo daaweynta kor ku qoran, oo ay ka mid tahay laakiin aan ku koobnayn: <input checked="" type="checkbox"/> Warbixinta raajada <input checked="" type="checkbox"/> taswiiraha <input checked="" type="checkbox"/> Warbixinta fasaxidda <input checked="" type="checkbox"/> Warbixinta qalliinka <input checked="" type="checkbox"/> Warbixinta gargaarka <input checked="" type="checkbox"/> Warbixinta talo siintas <input checked="" type="checkbox"/> Kuwa kale
Purpose: This information is needed for the following Purpose: Use in the investigation and prosecution of the case(s): Muhimadda: Warbixintaan waxaa lagaaga baahan yahay sababaha soo socda: In loo isticmaalo marka kiiska la baarayo ama la xukumayo:	
State of Minnesota v /Gobolka Minnesota _____	
Case Number(s) /Kiis Lambarka _____	
15. This authorization will automatically expire one year from the date of my signature. 16. This authorization may be revoked by written request of the patient at any time to the address listed for the requesting entity. A revocation will not apply to information that has already been released in response to this authorization. 17. Once information is released pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rule, 45 CFR Parts 160 and 164. 18. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here:_____.Please indicate any restrictions: (Specify)_____. 19. This authorization must be filled out completely and signed and dated to be considered valid. 20. A copy of this authorization will be considered as valid as the original authorization. 21. Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon signing of this authorization form.	8. Oggolaanshahan waxuu dhacayaa hal sano ka dib taariikhdan saxiixay. 9. Oggolaanshahan waa laga noqon karaa iyadoo codsi qoraal ah oo ka socda bukaanka waqtigii la doono ayadoo loo gudbin doono cinwaanka kor ku xusan ee cidda waydiisatay. Ka noqoshadaas ma saameeyo warbixintii hore loogu soo gudbiyay. 10. Mar haddii warbixinta la gudbiyo ka dib markaad oggolaanshahan bixisay, warbixinta waxaa sii gudbin karaa qoladii hore aad ugu soo dirtay, mana dhowraayo xeerka ilaaliya warbixinta sirta ah ee qaanuunka, 45 CFR qeybaha 160 iyo 164. 11. Marka laga reebo xanuunka maskaxda, dhamaan diiwaannada ku saabsan cudurrada maskaxda gala, iyo marka qofka uu qaato waxyaabaha maskaxda doriya iyo/ama cudurrada la xiriira AIDS/HIV la baarayo haaddji aadan ruqso bixin:_____. Fadlan caddee hadiii ay wax ku xayiraajiraan: (Qeex) _____ 12. Oggolaanshahaan waa in la saxiixaa si dhameystiran loo buuxshaa la saxiixaa taariikhna lagu qoro si uu u ansaxo. 13. Koobi haddji laga sameeyo oogolaanshahaan waa loo isticmaali karaa sidii midka. 14. Daaweynta, kharajka adeegyada, is diiwaangelinta iyo xaq u lahaanshaha faa'iidada kuma xirna in la saxiixo foomkaan.
Patient's /Authorized Person's Signature: Bukaanka/Qofka Saxiixaya:	
Signature of Patient/Authorized Person/ _____ Saxiixabukaanka/Qofka Usaxiiaa	Date/Taariikhda _____
Authorized Person's Authority to Sign/AwoodaaQofausaxiia _____	
Reason Patient is unable to sign/Sababta bukaanku aanu u saxiixi Karin: <input type="checkbox"/> Minor/Ma qaan gaarin <input type="checkbox"/> Deceased/Qof Dhintay <input type="checkbox"/> Other/Sabab Kale _____	

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Authorization for Release of Private Health Information

Ntawv Tso Cai Tso Lus Kom Qhib Cov Ntawv Hais Txog Tus Kheej Kev Noj Qab Haus Huv

Patient/Tus Tub Mob: Name/Luv npe Birth Date/Hnub yug Address/Chaw nyob City/Zos State/Xeev Zip Code/Leb Date of Injury/Hnub raug mob Date(s) of Treatment/(Cov) Hnub mus kuaj mob

Information to be Released to/Tso Cai Qhib Cov Ntawv Rau: Office of the Minneapolis City Attorney / Minneapolis Lub Hoob Kaas rau Kws Lij Choj 333 S. 7th Street, Suite 300 Phone/ Xov tooj: 612-673-2010 Minneapolis, MN 55402 Fax: 612-673-2189

Custodian of Records/Qhov Chaw Tuav Ntaub Ntawv: Hospital/Doctor Tsev Kho Mob/ Chaw kuaj mob/ Thaj maum Address/Chaw nyob Telephone/Xov Tooj

Information to be Released: All [] certified / [] uncertified Medical records pertaining to the above-referenced incident date treatment date(s), including but not limited to: [] x-ray/radiology reports [] photographs [] discharge summary [] operative reports [] ER reports [] consultation reports [] other Con Ntawv Tso Cai Qhib Yog: Tag nhro [] cov ntawv kuaj mob qhia tau tias muaj tiag losyog/ [] cov ntawv kuaj mob ua qhia tsis tau tias muaj tseeb hais txog lub sib hawm muaj nyob rau daim ntawv nos thiab cov hnub tau mus kuaj mob, raws li cov nram no tabsis tsis yog tag rau qhov muaj nos xwb: [] duab fais fab/tus thaj fais fab cov ntawv sau [] duab [] ntawv sau ua ntej tso tawm haus maum [] ntawv sau txog kev phais [] chav kuaj mob kub ceev(ER) cov ntawv sau [] ntawv sau txog kev sab laj [] lwm yam ntawv

Purpose: This information is needed for the following Purpose: Use in the investigation and prosecution of the case(s): Lub Ntsiab Xav Tau: Cov ntaub ntawv coj los siv raws li muaj nos: Coj los xwj thiab txiav ntxim rau rooj plaub (cov plaub): State of Minnesota v/Lub Xeev Minnesota xub Case Number(s) /Rooj Plaub tus zauv(s)

- 22. This authorization will automatically expire one year from the date of my signature.
23. This authorization may be revoked by written request of the patient at any time to the address listed for the requesting entity.
24. Once information is released pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rule, 45 CFR Parts 160 and 164.
25. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: ____ Please indicate any restrictions: (Specify) ____
26. This authorization must be filled out completely and signed and dated to be considered valid.
27. A copy of this authorization will be considered as valid as the original authorization.
28. Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon signing of this authorization form.
15. Daim ntawv tso cai hnub tas kas nuv yog ib lub xyoo tom qab hnub kuv kos npe rau daim ntawv tso cai.
16. Daim ntawv tso cai nos muab tshem tawm thaum twg los tau tsuas tus tub mob sau ntawv mus qhia rau qhov chaw nyob uas xav tau cov ntaub ntawv li saum toj nos.
17. Yog thaum twb xa cov ntaub ntawv raws li daim ntawv tso cai lawm nos ces, cov ntaub ntawv nos yuav tsis muaj kev tiv thiav los ntawm tsoom fwm txoj cai 45 ua tsis pub qhia tawm CFR txheej 160 thiab 164 vim cov ntaub ntawv twb tau muab xa mus rau lwm qhov chaw lawm.
18. Cov ntaub ntawv kuaj thaj maum nyuaj siab, tag nrho cov ntawv kuaj hlwb/cim seeb tsis zoo, siv dej cawv los yog tshauj yeeb thiab kev muaj mob xws li AIDS/HIV yuav pub qhib tawm tabsis yog tsis pub qhib tawm nos ces khij qhov nos: ____ Thov sau txog txhua yam txwm tsis pub qhib tawm:(sau kom meej) ____
19. Daim ntawv tso cai nos yuav tsum teb kom tiav thiab kos npe kom tag ua ntej yuav siv tau.
20. Daim ntawv tso cai uas muab luam dua tshiab yuav muab siv tau ib yam li daim tiag.
21. Kos npe rau hauv daim ntawv tso cai nos yuav txhais tsis tau tias yuav tau txais kev kuaj mob, kev pab them nyiak rau cov kev pab tau txais, ua ntawv ncuv npe kom tau txais nyiaj ntawm lav thab. npas.

Patient's /Authorized Person's Signature / Tus Tub Mob/Tus Neeg Muaj Cai Kos Npe: Signature of Patient/Authorized Person / Date/Vas nthib Tub mob kos lub npe/ Tus neeg muaj cai Authorized Person's Authority to Sign/Tus Neeg tau cai kos lub npe Reason Patient is unable to sign/Vim li cas Tus Tub Mob kos tsis tau nws lub npe: [] Minor/tsis tau muaj 18 xyoo [] Deceased/Tas sim neej [] Other/Lwm yam

PLEASE BE SURE SHADED AREAS ARE COMPLETED BEFORING HAVING RELEASE SIGNED.