MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

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mn.gov/boards/hpsp

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant Name: First Middle Last		**DOB:**
Party: Medical Records		
Agency:	**Provider's Name:**	
Phone:	**Fax:**	**E-mail:**
Street Address:		
City:	**State:**	**Zip:**

This authorization is (check one): ☐ **New** ☐ **Renewal** ☐ **Replacing**

PURPOSE OF DISCLOSURE: You are authorizing HPSP to obtain medical records for the purpose of determining your eligibility for HPSP services, to establish and implement a Participation Agreement, and to provide ongoing monitoring services.

This authorization covers the release of all records prior to the date of signature and all records after the date of the signature for one year.

INFORMATION TO BE DISCLOSED FROM THE ABOVE-NAMED ORGANIZATION TO HPSP:

Service dates from (mm/dd/yyyy) _____ / _____ / _____ **to one year from the date of signature.**

Medical History, Assessment, Treatment and Status	X	Continuing Care Plan	X
Mental Health History, Assessment, Treatment and Status	X	Work Quality and Ability	X
Substance Use Disorder History, Assessment, Treatment and Status	X	Admission/Discharge/Transfer Summaries	X

I understand that my decision to allow release of the data to HPSP is voluntary.

- This authorization expires at the end of one year from the date of signature, unless expressly removed in writing earlier.
- I may revoke this authorization at any time by notifying HPSP and the providing individual/organization in writing, and it will be effective on the date notified except for information that has already been released under this authorization.
- The information provided to HPSP may be accessible to HPSP medical consultants and other providing organizations authorized to exchange information.
- The information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law. Data obtained by HPSP is subject to Minnesota Statutes chapter 13 and section 214.35

PARTICIPANT SIGNATURE: _____ **DATE:** _____