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**HIPAA COMPLIANT REQUEST FOR RELEASE OF PATIENT INFORMATION**

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| **TO:** Click or tap here to enter text.(Name of Healthcare Provider/Physician/Facility) |
| Street Address: Click or tap here to enter text. |
| Fax Number: Click or tap here to enter text. |
| **RE** Patient Name: Click or tap here to enter text. | Date of Birth: Click or tap here to enter text. |
| The patient named above is a Blue Plus SecureBlue (MSHO) or Blue Advantage MSC+ member. As the patient’s Health Plan Care Coordinator, it is my responsibility to support patient education and self-care and facilitate implementation of physician orders after discharge. The Minnesota Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) Medical Assistance Application for beneficiaries over the age of 65 (DHS Form 3876) authorizes sharing of medical information between health providers and health plan contractors to facilitate coordination of health care services.  |
| **RELEASE INFORMATION VIA SECURE EMAIL OR FAX TO:** |
| Care Coordination Delegate Agency: Click or tap here to enter text. |
| Attn Care Coordinator: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |
| Fax Number: Click or tap here to enter text. |
| I request the release of healthcare information of the patient named above for the purpose of coordination of medical care. This request and authorization applies to:* Discharge orders from the most recent hospitalization of the patient, including orders related to medications, and a list of the conditions and medication intolerances or allergies of the patient; and
* Prescription information, including name, form, strength, dose, frequency, time of administration, and indication of each medication for the patient.
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| Signature of Requestor:  | Date: Click or tap here to enter text. |
| Printed Requestor Name: Click or tap here to enter text. |
| Phone: Click or tap here to enter text. | Email: Click or tap here to enter text. |
| **Please contact me directly with any questions.** |