Authorization for Release of Health Information

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ MEDICAL RECORD#:_____
MO DAY YR

DAY PHONE:_____ EVENING PHONE: _____

I authorize the release (disclosure) of my health information:

FROM: NAME: _____
ADDRESS: _____ CITY:_____ STATE: _____ ZIP:_____
PHONE: _____ FAX: _____

TO: NAME:_____
ADDRESS:_____ CITY: _____ STATE:_____ ZIP _____
PHONE: FAX:

PURPOSE OF DISCLOSURE: 🗀 Changing physicians 🗀 Consultation/second opinion 🗀 Continuing care 🗀 Legal 🗀 School 🗀 Insurance
🗀 Workers Compensation Other (please specify):_____

INFORMATION TO BE RELEASED (Typed of information, dates of service, and applicable information needed to precess request):

□ Clinic progess notes □ Allergy Skin Tests □ Other (Specify)
□ Lab reports □ Allergy Shot Schedules
□ CT Imaging and X-Ray reports □ Allergern Vaccine Formulas

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* WE WILL RELEASE OUR CLINIC RECORDS. For continuing care purposes, 2 years of physician notes, 1 year of lab/x-ray, reports can be sent to your provider at no charge. *

1. **I understand that the information released from my health record may include information relating to treatment of alcohol or drug abuse, behavioral or mental health services, as well as HIV/AIDS testing unless otherwise limited.**
2. I understand that this authorization will expire one year after I have signed the form or _____.
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance opon it.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
5. I understant that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or desclosure except (1) if my treatment is related to research, or (2) health care services provided to me solely for the purpose of creating protected health information for disclosure to a third party.
6. I understand that in compliance with Minnesota Statute, I will be charged a fee for the processing and copying of the release of my records if requesting greater than current medical care (or 2 years). I may also be charged for copies of x-ray films. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT **DATE** PARENT/LEGAL GUARDAIAN/AUTHORIZED PERSON **DATE**

_____ _____ _____
RECORDS RECEIVED BY **DATE** RELATIONSHIP TO PATIENT

THIS IS A LEGAL DOCUMENT, PLEASE READ IT AND FILL IT OUT COMPLETELY.

FOR OFFICE USE ONLY

IDENTIFICATION PRESENTED FOR SIGNATURE:_____ DATE REQUEST FILLED/BY WHOM:_____
IDENTIFICATION PRESENTED (IF OTHER THAN PATIENT PICKING UP) _____