Allergy, Asthma &
Immunology Clinic, P.A.

Phone 651.765.9800 **Fax: 651.765.9801**

Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____State:_____ Zip: _____
Home Phone: _____Cell Phone: _____Work Phone: _____

Information to be released from:
Doctor/Clinic Name: _____
Address: _____
City/State/Zip: _____
Phone: _____Fax: _____

Information to be release to:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____Fax: _____

Information to be released (Must check all that apply)

- ☐ Clinic Progress Notes
- ☐ Lab Reports
- ☐ CT/X-Ray reports
- ☐ Allergy Skin Tests
- ☐ Allergy Shot Schedules
- ☐ Allergen Vaccine Formulas
- ☐ Pulmonary Function Tests
- ☐ Other (Specify) _____

For the following dates of treatment or condition: _____ thru _____.
MM/YYYY MM/YYYY
Date information needed by: _____
Purpose of Release:

- ☐ Transferring Care
- ☐ Insurance application/change
- ☐ Legal/Attorney request
- ☐ Continuing Care
- ☐ Billing Information
- ☐ Personal Use
- ☐ Other _____

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 I may revoke this authorization 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 upon it.
3. I understand that this authorization will expire one year after I have signed the form or _____.
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 understand 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 disclosure except (1) if my treatment us a related to research or (2) health care services provide 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 Statue, I will be charged a fee for the processing and copying of the released 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 of medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

For Office Use Only

Identification presented for signature: _____ Date request filled/by whom_____

Identification presented (If other than patient picking up) _____