



Family Tree Clinic

1619 Dayton Avenue
St. Paul, MN 55104
Phone: (651) 645-0478
Fax: (651) 642-2523

**Please allow
7-10 days
for processing**

Authorization for Release of Medical Records

Patient's Last Name _____ First Name _____ MI _____

Family Tree # _____ Date of Birth ____/____/____ Patient's Phone #(____) _____ -- _____

Patient's Address _____

Maiden Name _____ Social Security # _____ - _____ - _____
City State Zip

I authorize the Family Tree Clinic to:

_____ Send medical records to: _____
Name of clinic

_____ Get medical records from: _____
Address

City, state, zip code

PHONE # _____

FAX # _____

Please mark which medical records you are requesting, *be as specific as possible.*

Visit notes *dates* _____ Sexually Transmitted Infection tests *dates* _____

Pap Smear/Colposcopy/Pathology Results *dates* _____ Other tests _____ *dates* _____

Depo Injection Records *dates* _____ Billing/Invoices *dates* _____

Other: _____

Needed for an appointment on this date: _____

I understand this authorization will expire in one year and that I can revoke this authorization with a written request.

I understand that once information is released pursuant to this authorization, Family Tree Clinic cannot prevent the redisclosure of the information to another third party for the purposes of treatment.

Patient Signature _____ **Date** _____

<i>Office Only</i>	
Date Records/Request sent _____	Staff Initials _____
Date Records Received _____	Staff Initials _____