Family Tree Clinic
1619 Dayton Avenue #205
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_____

City State Zip

Maiden Name _____ Social Security # _____-_____-_____

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 _____

Office Only

Date Records/Request sent _____Staff Initials _____

Date Records Received _____Staff Initials _____