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St. Paul, MN 55104
Phone: 651-645-0478
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Office only
Date Records/Request sent________________ Staff Initials______
Date Records Received ___________________ Staff Initials______

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	Legal Last Name:____ First Name:________________________ Preferred Name:____ Date of Birth:______________________ SS #:____ Address:____ City:____ State:___________ Zip:_____________________
Clinic/Hospital/Health Care Provider *(Who has the information you want released? Please list the specific clinic or provider)*	Provider Name:____ Name of Clinic or Hospital:____ Address:____ City:____ State:___________ Zip:_____________________ Phone:____ Fax:_______________________________________
Receiving Party *(Where do you want the information sent? Who may have the information?)*	Name: ____ Address:____ City:____ State:___________ Zip:_____________________ Phone:____ Fax:_______________________________________
Information to be Released *(What do you want sent or released? Check the appropriate box)*	Please indicate date(s) of service:____ ☐ Visit notes ☐ Hospital ☐ Any and all records ☐ Hormone related care ☐ STI results ☐ Pap smear / colposcopy / pathology <u>Only records types checked below:</u> ☐ Laboratory reports ☐ Emergency records ☐ Medication records ☐ Immunization records ☐ Imaging reports ☐ Chemical dependency records ________ (initials) ☐ Mental health records________ (initials) ☐ HIV test results ________ (initials) ☐ Ok to discuss protected health information (no records needed unless indicated above)
Release Instructions	Date information is needed:____
Purpose of Release	☐ Continuing care ☐ Insurance payment/claim ☐ Legal ☐ Personal use or review ☐ Transfer of care ☐ Other:__________________________________

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:______________
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Family Tree Clinic may include records that it received from other organizations. If these records have been used by Family Tree Clinic and filed in the record Family Tree Clinic maintains about you, these records may be released with your Family Tree Clinic records.
- Family Tree Clinic cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Family Tree Clinic from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

____ ____

Patient/Legal Guardian Signature **Today's date**

Note: please allow 7-10 days for processing