Family Tree Clinic
1619 Dayton Avenue
St. Paul, MN 55104
Phone: 651-645-0478
Fax: 651-642-2523

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_____ (initial for HIV results) ☐ Hormone related care ☐ STI results_____ (initial for HIV 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:_____ Receive records by: ☐ Mail ☐ Pick up ☐ Fax

- 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