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 Only records types checked below: ☐ 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:______________________
- You may cancel this authorization at any time by writing to Family Tree Clinic. 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.
- Family Tree Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether or not you sign this form.
- 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