FAMILY TREE CLINIC
1919 Nicollet Avenue
Minneapolis, MN 55403
Phone: 612-473-0800

Label Here

Authorization to Disclose Patient Information

Patient Information

Preferred Name:_____ Legal First Name:_____

Legal Last Name:_____

Date of Birth: _____ Phone Number:_____ Last 4 of SSN:_____

Address:_____

Email Address:_____

I authorize Family Tree Clinic to:

- ☐ Share Billing/Insurance information
- ☐ Make/Cancel/Change Appointments
- ☐ Share Protected Health Information
- ☐ Communicate with the patient at the receiving party's phone number (see below)
- ☐ Other (please describe): _____

Please use ROI form for all records releases.

with this **Receiving Party**

Name:_____ Phone Number: _____

Address:_____

Relationship to Patient: _____

- 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 Date