Label Here

FAMILY TREE CLINIC
1919 Nicollet Avenue
Minneapolis, MN 55403
Phone: 612-473-0800
Fax: 612-236-4745

AUTHORIZATION TO RELEASE INFORMATION

Please allow 7-10 business days for processing.

PATIENT INFORMATION

Legal Name: _____ **Date of Birth:** _____

Preferred Name / Pronouns: _____ **Phone Number:**_____

INFORMATION REGARDING REQUEST

I authorize Family Tree Clinic *(1919 Nicollet Ave S, Minneapolis MN 55403, Phone: 612-473-0800, Fax: 612-236-4745)*
to: □ Send records to □ Receive records from □ Discuss Protected Health Information with

The following:
Provider / Clinic / Hospital Name:_____

Street Address: _____

City: _____ State:_____ Zip:_____

Phone: _____ Fax:_____

RECORDS TO BE EXCHANGED

□ visit notes
□ STI results
□ laboratory reports
□ pap smear / colposcopy *(request >1 year below)*
□ medication records
□ immunization records
□ imaging reports
□ hospital / emergency records
□ other: _____

Special Permissions - Please initial below to consent for the following records to be included in the release.
____ Include HIV results
____ Include chemical dependency records
____ Include mental health records

Date of service range default is one year prior to signature, unless □otherwise requested:_____

Purpose of Release
□ continuing / transferring care
□ insurance payment / claim
□ other: _____
□ legal
□ personal review

Send Records Via: □ fax (preferred)
If fax is not available, also okay to send via:
□ mail □ pick up (in person at FTC)

Additional Information Regarding Request: _____

Authorization lasts for one year unless otherwise requested. I would like my authorization to expire 14 days after the following date: _____
-You may cancel this authorization any time by writing to Family Tree Clinic.
-A cancellation will not change releases completed before the cancellation.
-A photocopy/fax of this authorization will be treated 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 the 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.

_____ _____

Signature of Patient or Legal Representative **Date**