

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)



1 PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth
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2 CURRENT OR FORWARDING ADDRESS AND TELEPHONE:

Street Address	City	State	Zip code	Phone
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3 I AUTHORIZE THE RELEASE OF MEDICAL RECORDS FROM:

- 111 Hundertmark Road, Suite 420 • Chaska, MN 55318 • Fax: 952-473-7908
- 916 St. Peter Avenue, Suite 120 • Delano, MN 55328 • Fax: 952-473-7908
- 9325 Upland Lane North, Suite 111 • Maple Grove, MN 55369 • Fax: 952-473-7908
- 14001 Ridgedale Drive, Suite 100 • Minnetonka, MN 55305 • Fax: 952-473-7908
- 4695 Shoreline Drive, Suite A • Spring Park, MN 55384 • Fax: 952-473-7908

4 PLEASE RELEASE MY PROTECTED HEALTH INFORMATION (PHI) TO:

Clinic or Individual's Name	Phone	Fax
Street Address		
	City	State
		Zip code

5 IN THE FORMAT SELECTED:

- Paper Email CD

6 DATE INFORMATION NEEDED:

- Please choose: Fax Mail Pick up Email _____

7 PURPOSE OF RELEASE (Check all that apply):

- | | |
|---|--|
| ➤ Transfer of care due to: <ul style="list-style-type: none"> <input type="checkbox"/> New primary care clinic <input type="checkbox"/> 18+ or older/new primary clinic <input type="checkbox"/> Out of town/state move <input type="checkbox"/> Insurance change | ➤ Non-transfer request: <ul style="list-style-type: none"> <input type="checkbox"/> Consultation/Second Opinion <input type="checkbox"/> Personal or school-related <input type="checkbox"/> Legal (<i>charges apply</i>) <input type="checkbox"/> Life Insurance application (<i>charges apply</i>) |
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8 SPECIFIC INFORMATION REQUESTED:

- Vaccine records, **no charge**
- Clinic visit notes, lab and x-ray results, medication list (**first release, most recent two years: no charge**)
- All or additional records after most recent two years: **\$25.00 Flat Fee, payable in advance to Wayzata Children's Clinic.**
- Other, specific information only (*please explain*) _____

9 AUTHORIZATION:

I understand that Wayzata Children's Clinic, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form. I must sign in order to release my protected health information. This authorization is valid for information disclosed for purpose of treatment, payment and health care operations **for one year unless otherwise specified**. I understand that I can revoke this authorization at any time in writing. I understand that once information is released pursuant to this authorization, Wayzata Children's Clinic, P.A. cannot prevent the redisclosure of the information to another third party.

Signature of Patient or Guardian	Printed Name	Relationship	Date
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(Patients 18 years or older are legally required to sign any/all authorizations)