NEW PATIENT

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Wayzata Children's Clinic

❶ PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth

❷ CURRENT ADDRESS AND TELEPHONE:

_____

Street Address City State Zip code Phone

❸ I AUTHORIZE THE RELEASE OF MEDICAL RECORDS FROM:

_____

Clinic Name Phone Fax

_____

Street Address City State Zip code

❹ PLEASE FAX TO: 952-473-7908

- ❑ 111 Hundertmark Road, Suite 420 • Chaska, MN 55318 • 952-448-3847
- ❑ 916 St. Peter Avenue, Suite 120 • Delano, MN 55328 • 763-230-2780
- ❑ 9325 Upland Lane North, Suite 111 • Maple Grove, MN 55369 • 763-324-8000
- ❑ 14001 Ridgedale Drive, Suite 100 • Minnetonka, MN 55305 • 952-473-0211
- ❑ 4695 Shoreline Drive, Suite A • Spring Park, MN 55384 • 952-495-8910

❺ PURPOSE OF RELEASE:

➢Transfer primary care due to:

- ❑ New primary care clinic
- ❑ Out of town move
- ❑ Insurance change
- ❑ Consultation/second opinion

❻ DATE INFORMATION NEEDED:_____

❼ SPECIFIC INFORMATION REQUESTED:

- ❑ Vaccine records
- ❑ Clinic visit notes, lab and x-ray results, medication list (*for the most recent two years of service)*
- ❑ Other, specific information only *(please explain)* _____

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❽ 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.

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Signature of Patient or Guardian Printed Name Relationship Date

(Patients 18 years or older are legally required to sign any/all authorizations)

Revised – 9/6/2019 cm