AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Wayzata Children's Clinic

1 PATIENT NAME:

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

2 CURRENT OR FORWARDING ADDRESS AND TELEPHONE:

_____

Street Address City State Zip Code Phone

3 I AUTHORIZE THE RELEASE OF MEDICAL RECORDS FROM:

_____

Clinic or Individual's Name Phone Fax

_____

Street Address City State Zip code

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

_____

Clinic or Individual's Name Phone Fax

_____

Street Address City State Zip code

5 REQUESTED METHOD OF RELEASE:

❑ **Mail (Fees may Apply)** ❑ **Fax** ❑ **Pick Up @ Wayzata Children's Clinic**

❑ **Email**_____

6 DATE INFORMATION NEEDED:_____

7 PURPOSE OF RELEASE (Check all that apply):

➢ Transfer of care due to:
- ❑ New primary care clinic
- ❑ 18+ or older/new primary clinic
- ❑ Out of town/state move
- ❑ Insurance change

➢ Non-transfer request:
- ❑ Consultation/Second Opinion
- ❑ Coordination of Care
- ❑ Personal or School-related
- ❑ Legal & Life Insurance application *(fees may apply)*

8 INFORMATION TO BE RELEASED:

- ❑ Clinic visit notes to include lab and x-ray results, medication list, & immunizations for the last 2 years.
- ❑ All Clinic Health Records (fees may apply)
- ❑ Other, specify information _____

_____

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

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