Request received by: \_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_

# Authorization for Release of Protected Health Information

**PATIENT INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Last, First, MI) Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City/State/Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # Work Phone # Cell Phone #

**RELEASE RECORDS TO: FROM: RELEASE RECORDS TO: FROM:**

St. Paul Allergy & Asthma Clinic, P.A. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

565 Snelling Avenue South Name (Clinic, Physician)

St. Paul, MN 55116 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Send to the attention of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address

Phone: (651) 698-0386 Fax: (651) 698-0483 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/State/Zip

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone number Fax number

**WHICH RECORDS ARE TO BE RELEASED (check all applicable categories):**

Entire Record Office Visit Notes Pulmonary Function Test Lab Reports

Skin Testing X-ray/CT Scan Reports Hospital Records Immunology

Serum Formula Allergy Shot History Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE FOR RELEASE: DATE NEEDED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Continuing Care Application for Insurance Transfer of Care Legal/Attorney Request Insurance Claim or Payment School

 Work Comp Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ACKNOWLEDGEMENT OF UNDERSTANDING:**

|  |
| --- |
| * I may revoke this authorization at any time by providing notification in writing, and it will be effective on the date notified except to the extent the action has already been taken.
 |
| * I understand this authorization is valid for one year from the date signed, unless the authorization states a different time period, or the consent is revoked prior to its expiration.
 |
| * I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and Rule 164.524.
 |
| * I understand when St. Paul Allergy & Asthma Clinic discloses PHI pursuant to this authorization, the information may no longer be protected by Federal or State privacy rules and may be subject to re-disclosure by the recipient of the information.
 |
| * I understand by signing this authorization, I agree to allow St. Paul Allergy & Asthma Clinic and all their staff members to disclose the following protected health information to the above stated person(s) or entity.
 |
| * I understand by signing this authorization, I agree to all its contents and release St. Paul Allergy & Asthma Clinic from any and all liability resulting from re-disclosure.
 |
| * I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
 |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

(age 18 or over must sign for release of their records)