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: ☐**

St. Paul Allergy & Asthma Clinic, P.A.
565 Snelling Avenue South
St. Paul, MN 55116
Send to the attention of: _____
Phone: (651) 698-0386 Fax: (866) 314-4031

**RELEASE RECORDS TO: ☐ FROM: ☐**

_____
Name (Clinic, Physician)

_____
Street Address

_____
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)