

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION 7/7/2016

PATIENT NAME (Current and Previous) \_\_\_\_\_

DOB: \_\_\_\_\_ SSN \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

<b>Provider</b> Who has the information?	<input type="radio"/> Hospital <input type="radio"/> Clinic <input type="radio"/> Other	<b>Name and Address:</b> <u>Parkview Medical Clinic</u> <u>PO Box 186, New Prague MN 56071</u> Ph: <u>952-758-2535</u> FAX: <u>952-758-6101</u>
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<b>Requestor</b> Who needs the information?	<input type="radio"/> Patient <input type="radio"/> Hospital <input type="radio"/> Clinic <input type="radio"/> Other	<b>Name and Address</b> _____ _____ Ph: _____ FAX: _____
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<b>Information Required</b>	<input type="radio"/> Consultation Reports <input type="radio"/> Discharge Summaries <input type="radio"/> EKG Reports <input type="radio"/> ER Reports <input type="radio"/> History & Physical <input type="radio"/> Immunization Record	<input type="radio"/> Lab Data <input type="radio"/> Operative/Outpatient Reports <input type="radio"/> Clinic Visit Notes <input type="radio"/> Pathology Reports <input type="radio"/> X-Ray Films / X-Ray Reports <input type="radio"/> Other _____
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<b>Medical Condition/Injury And Time Period</b>	Dates and Description of Condition/Injury: _____ _____
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<b>Restrictions (optional)</b>	List Restrictions regarding information to be released: _____ All records pertaining to mental health, chemical dependence, AIDS-related illness, Sickle Cell Anemia, and/or alcohol abuse will be released unless otherwise indicated here: _____ _____
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<b>Purpose of Release</b>	<input type="radio"/> Continued Care <input type="radio"/> Education/Research <input type="radio"/> Moving Out of Town <input type="radio"/> Legal	<input type="radio"/> Consult/ Second Opinion/ Personal <input type="radio"/> Insurance Claims Process or Work Comp <input type="radio"/> Selected New Physician <input type="radio"/> Other _____
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**REVOCATION:** I understand that I may revoke this consent in writing at any time and that the consent will automatically expire 12 months from the date of my signature. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, enrollment or eligibility for benefits). I understand that once information is released under this authorization, Parkview Medical Clinic and their employees and physician(s) cannot prevent the redisclosure of that information.

**AUTHORIZATION:** I authorize the above provider to release the information marked above to the recipient.

\_\_\_\_\_  
(Signature of Patient/Guardian)

\_\_\_\_\_  
(Relationship to Patient if Signed by Guardian)

\_\_\_\_\_  
(Date of Patient's Signature)

\_\_\_\_\_  
(Reason Patient Unable to Sign)

Records Copied: \_\_\_\_\_  
(Date)

By Whom \_\_\_\_\_

Medical record copies will be: Mailed \_\_\_\_\_ Picked Up \_\_\_\_\_ Faxed \_\_\_\_\_