AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION 6/16/2021

PATIENT NAME (Current and Previous)					
DOB:	SSN		Phone (H)		Phone (W)
ADDRESS:					
Provider Who has the info	ormation?	Name a O Hospital O Clinic O Other			FAX:
Requestor Who needs the info	ormation?	O Patient O Hospital O Clinic O Other	Name and Add	ress:	Parkview Medical Clinic 1400 1 st St NE, New Prague, MN 56071 Ph: 952-758-2535 Fax: 952-758-6101
Information Required	O Dis O EK O ER O His	nsultation Report scharge Summari G Reports Reports story & Physical munization Reco	es	0	X-Ray Films / X-Ray Reports
Medical Condit And Time Perio		Dates a	nd Description of Con	dition	/Injury:
Restrictions (op All records pertaining abuse will be release	g to mental	health, chemical	d here:	lated	e released: illness, Sickle Cell Anemia, and/or alcohol
Purpose of Rel	ease	O Continued (O Education/F O Moving Out O Legal	Research O Ir	nsurar electe	It/ Second Opinion/ Personal nce Claims Process or Work Comp ed New Physician
expire 12 months fror nealth care benefits (n the date o treatment, p uthorization	at I may revoke th f my signature. I a ayment, enrollme	understand I do not ha ent or eligibility for ben	ave to efits).	time and that the consent will automatically sign this authorization in order to obtain. I understand that once information is and physician(s) cannot prevent the
AUTHORIZATION:	authorize th	ne above provide	r to release the inform	ation	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:	(D=1.)		By Whom		
Medical record copi	(Date) es will be:	Mailed	Picked Up_		Faxed