AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION 6/16/2021

PATIENT NAME (Current and Previous)_____

DOB:_____ **SSN**_____**Phone (H)**_____ **Phone (W)**_____

ADDRESS:_____

Provider **Name and Address:** **Parkview Medical Clinic**

Who has the information?
O Hospital
O Clinic **1400 1st St NE, New Prague MN 56071**
O Other

Ph: 952-758-2535 FAX: 952-758-6101

Requestor
Who needs the information?
O Patient
O Hospital
O Clinic
O Other

Name and Address_____

_____

Ph:_____ FAX:____ _____

Information Required

O Consultation Reports
O Discharge Summaries
O EKG Reports
O ER Reports
O History & Physical
O Immunization Record
O Lab Data
O Operative/Outpatient Reports
O Clinic Visit Notes
O Pathology Reports
O X-Ray Films / X-Ray Reports
O Other_____

Medical Condition/Injury And Time Period

Dates and Description of Condition/Injury:_____

_____

Restrictions (optional) 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:

_____

_____

Purpose of Release

O Continued Care
O Education/Research
O Moving Out of Town
O Legal
O Consult/ Second Opinion/ Personal
O Insurance Claims Process or Work Comp
O Selected New Physician
O Other_____

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:_____ By Whom_____
(Date)

Medical record copies will be: **Mailed**_____ **Picked Up**_____ **Faxed** _____