Consultative
Health and Medicine

5520 Ridgewood Cove
Minnetrista, MN 55364

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT

Name (Last, First, MI): _____ DOB: _____ SSN: _____

Address: _____ City, State, Zip: _____ Phone: _____

INFORMATION TO BE RELEASED FROM

Name of health care provider, clinic, or facility _____
Address: _____
Date Requested: _____ Date Needed By: _____

INFORMATION TO BE SENT TO

By Fax, if less than 50 pages TO: _____ FAX: _____

By Mail if more 50 pages or more to: Consultative Heath and Medicine, P.A.
Attn: _____ (Please identify nurse practitioner)
5520 Ridgewood Cove
Minnetrista, MN 55364

INFORMATION TO BE RELEASED

_____ The most recent two years of clinic visit notes, problem list, lab reports, diagnostic reports, immunization records, medication list, hospital records, consultations, discharge summaries
_____ Other specific information (i.e. Specialty provider consult notes) please specify: _____

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE Health Care Provider (Medical Management/Transfer of care)

PATIENT AUTHORIZATION
I understand that my records may contain information regarding the diagnosis of treatment of HIV/AIDs, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

*Please **exclude** the following information from the records released
___ Drug/Alcohol abuse treatment & Diagnosis
___ HIV/AIDs diagnosis/treatment/testing
___ Sexually transmitted disease
___ Mental illness, psych diagnosis/treatment

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization, in writing, at any time. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization my redisclose it, at which time it may no longer be protected under privacy laws. I understand that there may be a copy fee associated with the medical record release. I understand the expiration of this authorization is one year from the date signed.

_____ _____ _____/_____/_____
Signature Printed Name Date

(Patient, legal guardian or authorized representative)
*If you are a legal representative, please include with this form a copy of supporting documentation of this status so that medical records can be sent without additional delay. Thank you.