AUTHORIZATION OF RELEASE FOR PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ Date of Birth: _____/_____/_____

I authorize the release of my protected health infomraiton as follows:

☐ All my records including all general health records, medical histories, examination and treatment notes, radiology and laboratory test results, consultation and referral notes, etc.

☐ My records related to treatment for (specific illness, injury, evaluation or date of service):

____

☐ Other records (please describe): ____

I FURTHER AUTHORIZE THE RELEASE OF THE ADDITIONAL INFORMATION BELOW

☐ HIV/AIDS RELATED INFORMATION
☐ INPATIENT MENTAL HEALTH RECORDS
☐ STD INFORMATION
☐ DRUG/ALCOHOL TREATMENT
☐ PSYCHOTHERAPY NOTES
☐ OTHER: _________________________________

RECORDS RELEASED FROM: ☐ My Medical Clinic

☐ Other Clinic or Physician: ____

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RECORDS RELEASED TO:

☐ My Medical Clinic - 1560 Beam Ave, Suite F, Maplewood, MN 55109
Phone: (651) 340-1455 Fax: 651-340-5421

☐ Other Clinic or Physician: Clinic name, Physician and full address_______________________________

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PURPOSE (CHECK ALL THAT APPLY):
☐ Further Medical Care
☐ Personal at my request
☐ Insurance Eligibility/Benefits
☐ Legal Investigation/Action
☐ Clearance for Work Exam

☐ Other: ____

EXPIRATION: This authorization is good until the following date: ____/_____/______

* If this item is left blank, the authorization will expire in one (1) year from the date signed

Your rights in connection with this authorization

I can ask for a copy of the protected health information that will be disclosed. A processing and/or copying charge may apply as permitted by law. I may revoke my authorization at anytime, but I must do so in writing to the clinic where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. I understand that my health information may not be protected from further disclosure by some entities receiveing my information under this authorization, and that My Medical Clinic has no control over subsequent disclosures by other entities.

____ ☐ Self ☐ Parent or Legal Guardian

Printed Patient or Guardian Name

____ Date: __________________

Patient or Guardian Signature

07.16.2015