Child and Teen Medical Center

Fridley:	**Blaine:**
500 Osborne Road NE	11107 Ulysses St NE
Fridley, MN 55432	Blaine, MN 55434

763-333-7733 Phone 763-333-7711 Fax

Authorization for Release of Protected Health Information

PATIENT INFORMATION:

Name (Last, First, MI) ______________________ Date of Birth

Street Address ______________________ City/State/Zip

Home Phone # ______________________ Daytime Phone #

RELEASE RECORDS TO:

Name/Clinic/Provider ______________________

____

Street Address ______________________

City/State/Zip

RELEASE RECORDS FROM:

Child and Teen Medical Center

- Blaine
- Fridley

WHICH RECORDS ARE TO BE RELEASED {check all applicable categories):

****Records will be released for the last 3 years only, unless otherwise specified****

O Office Visit Notes
O Lab Results
O Vanderbilt ADHD Assessments
O X-Ray Reports
O Physicals/Pre Ops
O Other: ______________________
O Entire Records
O Growth Charts

••• All records pertaining to a sensitive nature, such as STD testing and/or psychiatric/mental health will be released unless indicated here:

O *DO NOT RELEASE RECORDS OFA SENSITIVE NATURE AS DESCRIBED ABOVE*

PURPOSE FOR RELEASE:

O Further Medical Treatment O Change of Clinics O Legal/Attorney Request
O Other: ______________________

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand this authorization is valid for one year unless otherwise noted. Information will NOT be released past the date of signature unless specifically stated- Extended date:____________ Parental initials:_____________
- I understand that I may revoke this authorization at any time providing notification in writing and it will be effective on the date notified except to the extent action has already been taken.
- I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and Rule 164.524.
- I understand a copy of this authorization will be treated in the same manner as the original.
- I understand by signing this authorization I agree that Fridley Children's & Teenagers' Medical Center and all their staff members are allowed to disclose the following protected health information to the above stated person(s) of entity.
- I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
- I understand that once information is released pursuant to this authorization, Child and Teen Medical Center cannot prevent the re-disclosure of the information to another third party.
- I understand that all parties involved will adhere to the April 14, 2006 HIPAA ruling. In addition, HIPAA requires that all patients be able to access their own medical records, correct errors or omissions, and be informed how personal information is shared/u sed. Other provisions involve notification of privacy procedures to the patient.

Records from other facilities: It is the policy of Child and Teen Medical Center to release only medical information documented/dictated by Child and Teen health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need.

Signature:	Date:
Relation to patient:	Contact #:

For office use only:

*Date received:*______________ *Date completed:*____________ *Initials:*___________ *Original: chart/parent*