763-333-7733 Office   763-333-7711 Fax

BLAINE	FRIDLEY
11107 Ulysses St NE	500 Osborne Road-Suite 215
Blaine, MN 55434	Fridley, MN 55432

Authorization for Release of Protected Health Information *Form 200 (Rev 01-2006, 5/2013, 6/2018)*

PATIENT INFORMATION:

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

____
Street Address   City/State/Zip

____
Home Phone #   Daytime Phone #

RELEASE RECORDS TO: (circle one)

Child and Teen Medical Center
500 Osborne Road NE-Suite 215
Fridley, MN 55432

Child and Teen Medical Center
11107 Ulysses ST NE
Blaine, MN 55434

RELEASE RECORDS FROM:

____
Name/Clinic/Provider

____
Street Address

____
City/State/Zip

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

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

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

☐ ***DO NOT RELEASE RECORDS OF A SENSITIVE NATURE AS DESCRIBED ABOVE***

PURPOSE FOR RELEASE:

- ☐ Further Medical Treatment
- ☐ Change of Clinics
- ☐ Legal/Attorney Request
- ☐ 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 Child & Teen 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 & 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/used. Other provisions involve notification of privacy procedures to the patient.

Records from other facilities: It is the policy of Child & Teen Medical Center to release only medical information documented/dictated by Child & Teen Medical Center's 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: _________________
(age 18 or over must sign for release of their records)
Relationship to patient: ___________________________________

For office use only:
Date received: ________________ Date completed:_____________ Initials:____________ Original: chart/parent