ATTENTION: MEDICAL RECORDS

Request received by _____
Date _____

Authorization for Release of Protected Health Information

PATIENT INFORMATION

_____
Name (Last, First, MI) Birthdate

_____
Street Address City/State/Zip

_____
Home Phone # Work Phone # Cell Phone #

RELEASE RECORDS TO: ☐ FROM: ☐

Allergy & Asthma Specialists, P.A.
825 Nicollet Mall, Suite 1149
Minneapolis, MN 55402
Send to the attention of: _____

Phone: (612)-338-3333 Fax: (612)349-3838

RELEASE RECORDS TO: ☐ FROM: ☐

_____
Name (Clinic, Physician)

_____
Street Address

_____
City/State/Zip

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

☐ Entire Record ☐ Office Visit Notes ☐ Pulmonary Function Test ☐ Lab Reports
☐ Skin Testing ☐ X-ray/CT Scan Reports ☐ Hospital Records

☐ Immunology ☐ Serum Formula ☐ Shot History

Allergy & Asthma Specialists, P.A. will release serum formula and shot history to other allergy clinics. If the medical records are sent to another care giver, i.e. primary care, the serum formula and shot history will be released upon request.

☐ 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:

DATE NEEDED: _____

☐ Further Medical Treatment ☐ Application for Insurance ☐ Change of Clinics
☐ Legal/Attorney Request ☐ Insurance Claim or Payment ☐ Research

ACKNOWLEDGEMENT OF UNDERSTANDING:

- 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 this authorization is valid for one year from the date signed, unless the authorization states a different time period or the consent is revoked prior to its expiration.
- 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 when Allergy & Asthma Specialists, PA discloses PHI pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand by signing this authorization, I agree to allow Allergy & Asthma Specialists, PA and all their staff members to disclose the following protected health information to the above stated person(s) or entity.
- I understand by signing this authorization, I agree to all its contents and release Allergy & Asthma Specialists, PA from any and all liability resulting from re-disclosure.
- I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

_____ _____
SIGNATURE (Patient / Legal Representative) DATE AUTHORITY to act on behalf of Patient
(age 18 or over must sign for release of their records) (Attach document)