



Location: **Robbinsdale**
 Fax # 763-587-7989

Maple Grove
 763-494-7501

Osseo
 763-420-1901

Plymouth
 763-587-7701

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize: _____

NAME OF HEALTHCARE PROVIDER

Phone Number

To release my records to: _____

NAME

ADDRESS

CITY

ZIPCODE

PHONE #

FAX #

The disclosure is being made for the following purpose(s)

<input type="checkbox"/> Diagnosis & Treatment	<input type="checkbox"/> Legal
<input type="checkbox"/> Insurance/Billing	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Personal	

I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

Information to be released:	Date of Service*	Information to be released:	Date of Service*
<input type="checkbox"/> Pertinent Records of Continuing Care	_____	<input type="checkbox"/> Radiology Reports	_____
<input type="checkbox"/> Discharge Summaries	_____	<input type="checkbox"/> Radiology Films	_____
<input type="checkbox"/> History & Physical	_____	<input type="checkbox"/> OB/GYN Records	_____
<input type="checkbox"/> Clinic Notes (2 yrs)	_____	<input type="checkbox"/> Pediatric Records	_____
<input type="checkbox"/> Consultations	_____	<input type="checkbox"/> Immunizations	_____
<input type="checkbox"/> Pathology Reports	_____	Other: _____	_____
<input type="checkbox"/> Laboratory Reports	_____		_____

*If a date of service is not listed, North Clinic will release information going back 2 years only.

Authorization of Release of the Indicated Records below requires patient's initials:

	Patient's initials		Patient's initials
<input type="checkbox"/> HIV or AIDS		<input type="checkbox"/> Chemical Dependency	
<input type="checkbox"/> Psychotherapy/Mental Health		<input type="checkbox"/> Other:	

I release the above named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified. I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when North Clinic receives my notice in writing. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Patient/Representative Signature _____ Date _____

Representative Name (if applicable) _____ Relationship _____