metro OBGYN

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME_____ **BIRTH DATE**_____**SS#**_____

ADDRESS_____**CITY**_____

STATE_____ **ZIP**_____**TELEPHONE**_____

I AUTHORIZE RELEASE OF RECORDS ☐TO ☐FROM

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

Phone_____

Fax: _____

Delivery method of Medical Records:
☐Fax # _____
☐Mail to Address Above

I AUTHORIZE RELEASE OF RECORDS ☐TO ☐FROM

Metro OBGYN

Phone: 651-227-9141

Fax: 651-291-5992

☐Gallery Professional Bldg
17 W. Exchange St. #622
St. Paul, MN 55102

☐Woodwinds Birch Center
1875 Woodwinds Dr, Suite #100
Woodbury, MN 55125

☐Maplewood Professional Bldg
1655 Beam Ave, Suite #102
Maplewood, MN 55109

☐Apple Valley Medical Center
14655 Galaxie Ave
Apple Valley, MN 55125

INFORMATION TO BE RELEASED

- ☐ PROGRESS NOTES Approximate dates_____
- ☐ LAB RESULTS Approximate dates_____
- ☐ OPERATIVE REPORTS Approximate dates_____
- ☐ X-RAY/ RADIOLOGY REPORTS Approximate dates_____
- ☐ OTHER Approximate dates_____
- ☐ ALL

PURPOSE OF DISCOLOSURE

☐ Continuing Care ☐ Other_____

- Please indicate any restrictions.
  (Specify):_____
- I understand I may revoke this authorization at anytime by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- This authorization will automatically expire one year from the date of my signature, or_____ (period of time, for example 2 days, or 3 weeks or 5 months) from the date of my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Metro OBGYN cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.

_____ _____ _____

SIGNATURE OF PATIENT / AUTHORIZED PERSON | AUTHORIZED PERSON'S AUTHORITY TO SIGN (PARENT, GUARDIAN, POWER OF ATTORNEY, ETC.) | DATE

REASON PATIENT IS UNABLE TO SIGN: ☐ MINOR ☐ DECEASED ☐ OTHER: _____

Updated 3/7/2018