South Lake Pediatrics
Infant, Child & Adolescent Care

AUTHORIZATION AND CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

One patient and one entity per form

Patient Information	Name:		DOB:
	Address:		
	City:	State:	Zip:
Contact for Questions	Name:	Contact Number:	Relation to Patient:
Check one: ☐ Request From or ☐ Send To	South Lake Pediatrics ATTN: Health Information Management (HIM) 17705 Hutchins Drive, Suite 250 Minnetonka, MN 55345		Phone: 952-401-8265 Fax: 952-401-8242 (If more than 10 pages please mail records)
Check one: ☐ Request From or ☐ Send To	Clinic name, Hospital name, Parent/Guardian or Self:		Phone Number:
	Street Address:		
	City:	State:	Zip Code:
Method of Sending Records	☐ Mail ☐ Fax/Number:(____)_____ ☐ Flash Drive (not recommended for sending records to another clinic.) ☐ Pick up in office(circle one) Chaska Children's West Eden Prairie Maple Grove Minnetonka Plymouth		
Specify Information Requested or Requesting	☐ Office Visits ☐ X-ray Reports ☐ Lab Reports ☐ Immunization Record ☐ Growth Charts ☐ Verbal Communication between clinics ☐ Other (Specify):_____ Date: from_____ to _____		
Radiology Film Release (Staff use only)	☐ Original CD of X-ray from_____ (visit date)	☐ X-ray Reports: from_____ (visit date)	☐ X-rays Mailed ☐ X-rays Picked up
Specify Authorization for Release of information protected by State or Federal Law	**I specifically authorize for the release of information relating to:** ☐ Substance Abuse (alcohol/drug abuse) ☐ HIV-related information (AIDS-related testing) ☐ Mental Health (psychological testing/behavioral visits) ☐ Developmental Disabilities		
Purpose for Release	☐ Consultation/Specialist ☐ Personal ☐ Legal ☐ Transfer of Care-Reason:_____ ☐ If new insurance, please provide insurance name:_____		
Acknowledgement of Understanding	• **In compliance with MN Statute 144.292 and Federal rule 45 C.F.R.164.524, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.** • This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____ • I understand that I may revoke this authorization at any time 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. • I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal privacy regulations. • I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.		
Signature of Parent/Guardian	_____ *Patients 18 Years of age or older are legally required to sign authorization.		_____ Date

*All fields must be complete to ensure timely process of records.