



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: <input type="checkbox"/> Request From or <input type="checkbox"/> Send To	South Lake Pediatrics ATTN: Health Information Management (HIM) Phone: 952-401-8265 17705 Hutchins Drive, Suite 250 Fax: 952-401-8242 Minnetonka, MN 55345 (If more than 10 pages please mail records)			
Check one: <input type="checkbox"/> Request From or <input type="checkbox"/> Send To	Clinic name, Hospital name, Parent/Guardian or Self:		Phone Number:	
	Street Address:		Clinic Fax Number:	
	City:		State:	Zip Code:
Method of Sending Records	<input type="checkbox"/> Mail <input type="checkbox"/> Fax/Number:() <input type="checkbox"/> Flash Drive (not recommended for sending records to another clinic.) <input type="checkbox"/> Pick up in office (circle one) Chaska Children's West Eden Prairie Maple Grove Minnetonka Plymouth			
Specify Information Requested or Requesting	<input type="checkbox"/> Office Visits <input type="checkbox"/> X-ray Reports <input type="checkbox"/> Lab Reports <input type="checkbox"/> Immunization Record <input type="checkbox"/> Growth Charts <input type="checkbox"/> Verbal Communication between clinics <input type="checkbox"/> Other (Specify): _____			
	Date: from _____ to _____			
Radiology Film Release (Staff use only)	<input type="checkbox"/> Original CD of X-ray from _____ visit date	<input type="checkbox"/> X-ray Reports: from _____ visit date	<input type="checkbox"/> X-rays Mailed <input type="checkbox"/> 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: <input type="checkbox"/> Substance Abuse (alcohol/drug abuse) <input type="checkbox"/> HIV-related information (AIDS-related testing) <input type="checkbox"/> Mental Health (psychological testing/behavioral visits) <input type="checkbox"/> Developmental Disabilities			
Purpose for Release	<input type="checkbox"/> Consultation/Specialist <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Transfer of Care-Reason: _____ <input type="checkbox"/> If new insurance, please provide insurance name: _____			
Acknowledgement of Understanding	<ul style="list-style-type: none"> 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	_____			_____ Date

*Patients 18 Years of age or older are legally required to sign authorization.

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