Medical Record Release Authorization

Phone: 952-401-8300 Fax: 952-401-8242 | Email: healthinformation@slpeds.com

Patient Name___________________________ Maiden Name________________Date of Birth__________

Phone_____________________ Email Address____

Parent Name (if under 18)_______________________________ Parent Phone______________________

A) I hereby authorize records FROM:

Name _______________________________________

Address_____________________________________

City/State/Zip ______________________________

Phone#___________________Fax#_______________

B) Release records TO:

Name____

Address____

City/State/Zip____

Phone#____________________Fax#_____________________

C) For the purpose of:

☐ Litigation
☐ Disability/SSI
☐ Work Comp
☐ Self/Personal Copy
☐ Consultation/Specialist
☐ Transfer of Care (Permanently Leaving)

D) Date Range:____________________To:_________________

We will copy the last two years if a date range is not provided

☐ Visit notes and immunization
☐ Mental Health Evaluation or treatment
☐ Cardiology/EKG Reports
☐ Lab/Imaging/Diagnosis Reports
☐ Other _____________________

☐ *Confidential (Pregnancy Testing, Contraception Counseling, STI Testing, Substance Use Disorder Evaluation and Treatment)

NOTE: For those services marked with an asterisk (*) only the patient (including minors) can sign for release of records if the minor provided effective consent for such services under Minnesota Statutes Section 144.343.

E) Method of sending records:

☐ Fax ☐ Mail ☐ Email *(if within size limit)* ☐ Pick up at South Lake Pediatrics Location ____________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_________________________ (Date)   _______________________________________ (Signature of Patient/Parent/Guardian or Authorized Representative)

_________________________ (Date)   _______________________________________ (Signature of Patient/Parent/Guardian or Authorized Representative) ****Subject to Fees**

This authorization will expire one year from the above date unless I specify an expiration date: ______________________
(Expiration date of authorization)

****PLEASE READ** Fee Information ***South Lake Pediatrics*** contracts with Verisma Systems Inc. to copy and provide all medical records requested from our office. Verisma Systems Inc. reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage may be invoiced to you from Verisma Systems Inc., with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay Verisma Systems Inc. for your records.

Verisma Systems Inc: (866) 390-7404