



**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION/
PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION**

Patient Name (Last, First, M.I.) _____

Date of Birth _____

Street Address _____

Home Phone _____

City _____ State _____ ZIP code _____

Other Phone (work or cell) _____

INFORMATION RELEASED FROM

INFORMATION RELEASED TO

Name of Clinic	Name (hospital, clinic, attorney, insurance company, individual)
Street Address	Street Address
City State ZIP Code	City State ZIP code
Phone Fax	Phone Fax

INFORMATION TO BE RELEASED (mark all that apply):

- All medical records, excluding Radiology Films
- Records about specific condition: _____
- Other (please specify): _____
- Radiology Report(s)
- Radiology Films (see below)*
- Visit Notes
- Immunization Records
- Laboratory Report(s)
- Hospital Records

DATES OF INFORMATION TO BE RELEASED:

- Specific date of service: _____
- Other (please specify): _____
- All clinic records
- Last 1 year
- Last 2 years
- Last 6 months

All records regarding mental health and/or HIV related illnesses will be released unless indicated here:

- DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV

REASON FOR RELEASE OF INFORMATION:

- Referral for medical care
- Transfer of medical care
- Other (please specify): _____
- Legal/Litigation
- Insurance claim or payment
- Insurance application
- Personal use

Authorization expiration date or event: _____ (If left blank, authorization will expire one year from date of signature.)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Southdale OB/GYN Consultants will not refuse or restrict my treatment if I choose not to sign this Authorization. A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original. Further, I realize that Southdale OB/GYN Consultants cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Southdale OB/GYN Consultants is released from any and all liability resulting from redisclosure.

Signature of Patient

Date

Signature of Parent/Legal Representative

Date

* Radiology Films will be released only to the patient and MUST be returned to Southdale OB/GYN Consultants after use.

Southdale Obstetric & Gynecologic Consultants

edina 3625 West 65th Street · Suite 100 · Edina, Minnesota 55435 · 952.920.7001

burnsville 305 East Nicollet Boulevard · Suite 393 · Burnsville, Minnesota 55337 · 952.435.9505

southdaleobgyn.com