PEDIATRIC AND YOUNG ADULT MEDICINE, P.A.

Authorization for Release of Patient Health Information

☐ I Hereby Authorize Pediatric and Young Adult Medicine to **REQUEST** information **FROM:**

Clinic Name:_____

Address: _____
Street City/State/Zip Code Phone/Fax#

☐ I Hereby Authorize Pediatric and Young Adult Medicine to **RELEASE** information **TO:**

Clinic Name:_____

Address: _____
Street City/State/Zip Code Phone/Fax#

Regarding the following patient(s):

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Records to be released:
The only records that are able to be released are records that are generated by Pediatric and Young Adult Medicine unless patient was referred

☐ Entire Record ☐ History and Physical ☐ Laboratory Report ☐ X-Ray Report ☐ Progress Notes

☐ Other _____

Time period of care to be released: _____ **to** _____
(Please be advised that if you request more than the last four years, requests may take up to two weeks to be processed)

Purpose of Release:
☐ Continuing care for on going treatment ☐ Transfer of Care ☐ Insurance ☐ Personal

Statement of Authorization:

- This authorization expires (1) year after the date of my signature below
- I understand that Pediatric and Young Adult Medicine will not condition my treatment, payment, enrollment, or eligibility or benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is sent as specified in this authorization, Pediatric and Young Adult Medicine, and their employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I understand that if I need to request information on chemical dependency, psychotherapy, and/or HIV/AID testing that a separate release must be completed in order to receive that information.

_____
Signature of legally Authorized Representative/Patient Date

_____
Print Name Phone # Relationship to Patient

Location
(Please check all locations that the patient has been seen at)

☐ 233 Grand Avenue **St. Paul**, MN 55102 ☐ 3420 Denmark Avenue **Eagan**, MN 55123 ☐ 1610 Maxwell Drive STE 245 **Hudson**, WI 54016
☐ 1655 Beam Avenue STE 108 **Maplewood**, MN 55109 ☐ 8650 Hudson Boulevard STE 125 **Lake Elmo**, MN 55042

Please mail all releases to the Grand Avenue office or fax to Medical Records at 651-256-6731 or 651-256-6710