

SOUTHDALE PEDIATRIC ASSOCIATES LTD.

**PATIENT AUTHORIZATION FOR
RELEASE OF INFORMATION**

PATIENT INFORMATION	Print Legal Name: _____ Date of Birth: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Parents/Guardian: _____
Health Information Released FROM:	<input type="checkbox"/> Southdale Pediatric Associates <input type="checkbox"/> Other Person/Organization: _____ Address: _____ Phone: _____ FAX: _____
Health Information Released TO:	<input type="checkbox"/> Southdale Pediatric Associates <input type="checkbox"/> Other Person/Organization: _____ Address: _____ Phone: _____ FAX: _____
INFORMATION REQUESTED	<input type="checkbox"/> Clinic Visit notes <input type="checkbox"/> Immunization records <input type="checkbox"/> Lab reports <input type="checkbox"/> Xray reports Dates: _____ <input type="checkbox"/> Other: _____ Southdale Pediatrics will only release records generated at our facility, if you need records from another facility you must request them from that facility.
PURPOSE FOR RELEASE	<input type="checkbox"/> Personal Copy <input type="checkbox"/> Moving <input type="checkbox"/> Referral to specialist <input type="checkbox"/> Insurance <input type="checkbox"/> Changing Providers <input type="checkbox"/> Other _____
METHOD OF DELIVERY	<input type="checkbox"/> Paper copies <input type="checkbox"/> Mail or <input type="checkbox"/> Pick up (must be 7-10 business days after date signed): _____ Picture ID is required when picking up records. Written permission is required if someone other than parent/ legal guardian or patient is picking information up.
CHARGES FOR COPIES	Requests for copies of CURRENT MEDICAL RECORDS (PREVIOUS TWO YEARS) generated by Southdale Pediatric Associates, Ltd. for personal use or to be sent to another physician will be PROVIDED AT NO CHARGE. Copies of COMPLETE MEDICAL RECORDS will be provided at a rate consistent with Minnesota statute 144.292. If complete copies are requested, we will notify you regarding the total charge prior to copying.
AUTHORIZATION/ REVOCATION	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to Southdale Pediatric Associates, Ltd. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Southdale Pediatrics will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X _____ X _____ Signature Date (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) _____ Relationship to patient (if not patient) NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. *A photocopy of this authorization is as valid as the original.