

OBSTETRICS, GYNECOLOGY AND INFERTILITY, P.A
Authorization to Disclose Health Information
(to Physician / Clinic / Patient)

This information must be filled out completely. Please print or type. Read each section and enter all of the required/requested information. If all areas are not filled out completely and accurately, this authorization will be returned to you requesting the additional needed information. If you have any questions on how to fill out this form, please call Obstetrics, Gynecology & Infertility.

Patient Name _____ Former Name _____

Date of Birth _____ SS # _____ Telephone # (____) _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. Obstetrics, Gynecology and Infertility, P.A. is authorized to make the disclosure. Please indicate the location of your records:
- | | | |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Edina office
6405 France Avenue S,
Suite W400
Edina, MN 55435 | <input type="checkbox"/> Maple Grove office
9550 Upland Ln No.
Suite 230
Maple Grove, MN 55369 | <input type="checkbox"/> Robbinsdale office
3366 Oakdale Avenue N.
Suite 305
Robbinsdale, MN 55422 |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|

3. The type and amount of information to be used or disclosed is as follows (check those that apply):
- Entire record Most recent history & physical Patient summary record Consultation reports
- Most recent operative report & hospital discharge summary
- Laboratory reports from (date) ____ / ____ / ____ to (date) ____ / ____ / ____
- X-ray & Imaging reports from (date) ____ / ____ / ____ to (date) ____ / ____ / ____
- Other, please specify _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavior and/or mental services and treatment for alcohol and drug abuse. If contained in the health record, this information may be disclosed unless indicated here by initialing on this line _____ and checking the information not to be disclosed.

Do not release the following information (please check those that apply and initial line in section # 4):

- AIDS or HIV Information Sexually Transmitted Diseases Behavior/Mental Services Drugs/Alcohol Abuse

5. Obstetrics, Gynecology and Infertility, P.A. is authorized to copy, disclose & send my medical records to the following Clinic / Organization / Individual (If the complete address is not provided, this request will be returned to you.):

(Name of Clinic / Individual / Organization receiving information)

(Address, City, State, Zip Code)

6. This information is needed for the purpose of _____.

7. I understand that I have the 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 revocation to Obstetrics, Gynecology and Infertility, PA. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____ (not to exceed one year from date signed). If I fail to specify any expiration date, event or condition, this authorization will expire in one year from the date signed.

8. 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 I may inspect or copy this information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure of the information and may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information; I can contact Obstetrics, Gynecology and Infertility, P.A.'s front desk receptionists at 952-920-2730 (Edina), 763-550-0056 (Plymouth) or 763-588-0703 (Robbinsdale).

By signing, I acknowledge that I have read, understand and agree with the above. By signing, I further understand that I may be charged in accordance with state and federal statutes for the processing of the requested records.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to the Patient
(03/09)

Signature of Witness