Authorization to Disclose Health Information
To: Obstetrics, Gynecology and Infertility, P.A.

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. **Once completed, please mail this authorization to the organization listed in section # 2** so that your medical record (protected health information) can be disclosed to Obstetrics, Gynecology and Infertility, P.A.

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. The following Clinic / Organization / Individual is authorized to copy, disclose and send my medical records to Obstetrics, Gynecology and Infertility, P.A.:

   _____
   (Clinic / Organization / Individual sending information)

   _____

   (Address, City, State, Zip Code)

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 above line in section # 4):

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

5. This information may be disclosed to and used by Obstetrics, Gynecology and Infertility, PA. Please indicate the location you would like your records mailed to:

   ☐ Edina office
   6405 France Avenue S,
   Suite W400
   Edina, MN 55435

   ☐ Maple Grove office
   9550 Upland Ln No.
   Suite 230
   Maple Grove, MN 55369

   ☐ Robbinsdale office
   3366 Oakdale Avenue N.
   Suite 305
   Robbinsdale, MN 55422

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 _____ (organization listed in section #2). 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 should contact the organization listed in section #2.

   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 Signature of Witness

(03/09)