Burnsville Family Physicians, P.A.
625 E Nicollet Blvd, Suite 100
Burnsville, MN 55337
952-435-0303

My Chart Access

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. Patient Name______________________________________Primary Care Physician_______________________
(***Please print clearly***)
Previous Names _____________Social Security #___________________________Birthdate______/____/_______

Phone Numbers (Homes)______________(Work) ____________________(Email) _________________________
Access to dependent info:
2. Patient Name______________________________________Medical Record # ____________________________

Previous Names _____________Social Security #___________________________Birthdate______/____/_______

3. Patient Name______________________________________Medical Record # ____________________________

Previous Names _____________Social Security #___________________________Birth date______/____/_______

4. Patient Name______________________________________Medical Record # ____________________________

Previous Names _____________Social Security #___________________________Birth date______/____/_______

This will authorize Burnsville Family Physicians to release medical information via My Chart to:
_____Myself ____Legal Guardian
_____To a Proxy that I have designated below (A proxy is a person who can access your information as if they were you.)

Name		Relationship
Street Address		
City	State	Zip Code

The following information is to be released: Any and all information over the course of the next year as allowed through My Chart.
I am requesting this information be released for the following purpose:
☐ Personal use ☐ Other____
If authorizing Proxy Access or access to a minor's record, this authorization is valid for a period of one year from the date of the signature. To renew access, call the phone number above or write to the address listed at the top of this authorization.

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- I understand that once information is released pursuant to this authorization, Burnsville Family Physicians, P.A. cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Except for research-related treatment, Burnsville Family Physicians, P.A. will not condition treatment on my signing this authorization.

____ ______________________________ _________________
Signature of Patient/Authorized Person
(***If authorized person is signing, please also print name***)

Authorized Person's authority to sign
(***parent, guardian, power of attorney, etc.***)

Date

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐Deceased ☐Other: ____________________________________