

**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      Date  
*(parent, guardian, power of attorney, etc.)*

REASON PATIENT IS UNABLE TO SIGN:  Minor  Deceased  Other: \_\_\_\_\_

