

Burnsville Family Physicians, P.A.
625 East Nicollet Blvd, Suite 100
Burnsville, Minnesota 55337
Main (952) 435-0303
Fax (952)892-5166

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # _____
(please print clearly)

Previous Names _____ Social Security # _____ Birthdate ____/____/____

Phone Numbers (Home) _____ (Work) _____ (Other) _____

This will authorize _____ to release information to _____
(other health care facility name) (Burnsville Family Physicians, P.A.)

This will authorize Burnsville Family Physicians, P.A. to release records to:

Name/Organization		
Street Address		
City	State	Zip Code

The following information is to be released (check appropriate boxes):

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> EKG/ECHO Reports |
| <input type="checkbox"/> Counselor's Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Department Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> X-Ray/Radiology Reports | <input type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Hospital Outpatients/Clinic Notes | <input type="checkbox"/> Films | _____ |

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Continued care by another provider | <input type="checkbox"/> Insurance claim purposes | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Attorney review | <input type="checkbox"/> Other _____ | |

- ◆ With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____
Please indicate any restrictions. (Specify) _____
- ◆ 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 information that has already been released in response to this authorization.
- ◆ This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
The expiration period noted here may exceed one year only in certain situations as specified by law.
- ◆ I understand there may be a retrieval and copy charge associated with the release.
- ◆ I understand that once information is released pursuant to this authorization, Burnsville Family Physicians, P.A. can not 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 _____ Authorized Person's authority to sign _____ Date _____
(If authorized person is signing, please also print name) (parent, guardian, power of attorney, etc.)

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____

Original - Chart /File Copy Patient / Authorized Person Copy
Authorization to Release Protected Health Information