

Please send correspondence to:

Northwest Professional Building
2351 Connecticut Ave S
Suite 200
Sartell MN 56377
320-259-1411
FAX 320-259-8967

Buffalo Clinic, PA
1700 Highway 25 N
Suite 120
Buffalo MN 55313
763-682-2268
FAX 763-682-2019



AUTHORIZATION FOR RELEASE OF INFORMATION

You must complete every section below or this form may be returned to you for completion.

| | |
|-----------------------------|---|
| Patient Name: _____ | Please circle: RELEASE TO or OBTAIN FROM |
| Date of Birth: _____ | _____ |
| Address: _____ | _____ |
| _____ | _____ |
| Phone #: _____ | Fax # _____ |

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Imaging CD |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Hospital Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Pathology Slides |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Other _____ | | |

TIMEFRAME: Records from ALL dates of service are being requested unless specific dates are listed below:

I would like records released from the following dates of service: _____ through _____.

PURPOSE OF RELEASE OF INFORMATION

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Further Treatment (appt. date: _____) | <input type="checkbox"/> Payment of Insurance Claim | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Insurance Application | <input type="checkbox"/> At request of patient | <input type="checkbox"/> Other: _____ |

I authorize the use and disclosure of my individually identifiable health information as described above, including written and verbal exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary and that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I also understand that the above records may contain information regarding STDs, HIV/AIDS, mental health, substance abuse or other sensitive information. This authorization will expire 12 months from date of signing or on ___/___/____, and includes information generated until that date. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized. I understand that my health care and payment for my health care will not be affected if I do not sign this form. A copy of this form is as effective as the original.

Signature of Patient/Guardian/ Representative

Date

If not patient, state authority/relationship

Reason patient unable to sign

For Office Use Only: _____

Copied / Printed / Faxed

Information Disclosed: Notes Labs Path X-Ray Hospital Diagnostics

Initials _____ Date: _____

DOS: _____ to _____

Other _____