Fridley Children's & Teenagers' Medical Center, P.A.

Unity Professional Building, Suite 215
500 Osborne Road NE
Fridley MN 55432
763-236-2700 Office 763-236-2710 Fax

Authorization for Release of Protected Health Information

PATIENT INFORMATION:

Name (Last, First, MI) Date of Birth

Street Address City/State/Zip

Home Phone # Daytime Phone #

RELEASE RECORDS TO:

Fridley Children's and Teenagers' Medical Center, P.A.
Unity Professional Bldg., Suite 215
500 Osborne Road NE
Fridley MN 55432

RELEASE RECORDS FROM:

Name/Clinic/Provider

Street Address

City/State/Zip

WHICH RECORDS ARE TO BE RELEASED: (check all applicable categories):

- ☐ Office Visit Notes
- ☐ Lab Results
- ☐ Vanderbilt ADHD Assessments
- ☐ X-Ray Reports
- ☐ Physicals/Pre Ops
- ☐ Other: _____
- ☐ Entire Records
- ☐ Growth Charts

*** All records pertaining to a sensitive nature, such as STD testing and/or psychiatric/mental health will be released unless indicated here:

- ☐ ***DO NOT RELEASE RECORDS OF A SENSITIVE NATURE AS DESCRIBED ABOVE***

PURPOSE FOR RELEASE:

- ☐ Further Medical Treatment
- ☐ Change of Clinics
- ☐ Legal/Attorney Request
- ☐ Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand this authorization is valid for one year unless otherwise noted. Information will NOT be released past the date of signature unless specifically stated- Extended date:_____ Parental initials: _____
- I understand that I may revoke this authorization at any time providing notification in writing and it will be effective on the date notified except to the extent action has already been taken.
- I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and Rule 164.524.
- I understand a copy of this authorization will be treated in the same manner as the original.
- I understand by signing this authorization I agree that Fridley Children's & Teenagers' Medical Center and all their staff members are allowed to disclose the following protected health information to the above stated person(s) of entity.
- I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
- I understand that once information is released pursuant to this authorization, Fridley Children's & Teenager's Medical Center cannot prevent the re-disclosure of the information to another third party.
- I understand that all parties involved will adhere to the April 14, 2006 HIPAA ruling. In addition, HIPAA requires that all patients be able to access their own medical records, correct errors or omissions, and be informed how personal information is shared/used. Other provisions involve notification of privacy procedures to the patient.

Records from other facilities: It is the policy of Fridley Children's & Teenagers' Medical Center to release only medical information documented/dictated by Fridley Children's & Teenagers' Medical Center's health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need.

Signature: _____ Date: _____
(age 18 or over must sign for release of their records)
Relationship to patient: _____

For office use only:
Date received: _____ *Date completed:*_____ *Initials:*_____ *Original: chart/parent*