1919 Nicollet Ave.
Minneapolis, MN 55403
phone: 612-473-0800
fax: 612-236-4745

Office only
Date Records/Request sent_____ Staff Initials_____
Date Records Received _____ Staff Initials_____

Label Here

FAMILY TREE CLINIC

AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION

Patient Information	Legal Last Name:_____ First Name:_____ Preferred Name:_____ Date of Birth:_____ SS #:_____ Address:_____ City:_____ State:_____ Zip:_____
Clinic/Hospital/Health Care Provider *(Who has the information you want released? Please list the specific clinic or provider)*	Provider Name:_____ Name of Clinic or Hospital:_____ Address:_____ City:_____ State:_____ Zip:_____ Phone:_____ Fax:_____
Receiving Party *(Where do you want the information sent? Who may have the information?)*	Name: _____ Address:_____ City:_____ State:_____ Zip:_____ Phone:_____ Fax:_____
Information to be Released *(What do you want sent or released? Check the appropriate box)*	Please indicate date(s) of service:_____ □ All records_____ (initial to release HIV results) □ Visit notes □ Hospital □ Hormone related care □ STI results_____ (initial to release HIV results) □ Pap smear / colposcopy / pathology <u>Only records types checked below:</u> □ Laboratory reports □ Emergency records □ Medication records □ Immunization records □ Imaging reports □ Chemical dependency records _____ (initial) □ Mental health records_____ (initial) □ HIV test results _____ (initial) □ Ok to discuss protected health information (no records needed unless indicated above)
Release Instructions	Date that the information is needed by:_____
Purpose of Release	□ Continuing care □ Insurance payment/claim □ Legal □ Personal use or review □ Transfer of care □ Other:_____ Receive records by: □ Mail □ Pick up □ Fax

- Authorization lasts for one year unless otherwise requested. **I would like my authorization to expire 14 days after the following date:** _____
- You may cancel this authorization any time by writing to Family Tree Clinic. A cancellation will not change releases completed before cancellation.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Family Tree Clinic may include records that it received from other organizations. If these records have been used by Family Tree Clinic and filed in the record Family Tree Clinic maintains about you, these records may be released with your Family Tree Clinic records.
- Family Tree Clinic cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Family Tree Clinic from any and all liability resulting from a redisclosure by the recipient.
- Family Tree Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether or not you sign this form.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____

Patient/Legal Guardian Signature **Today's date**

Please allow 7-10 days for processing