

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT INFORMATION

Patient Information	Name: _____ Date of Birth: ____/____/____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____																		
TO: (Who are records going to? Fill out completely and legibly)	Name: _____ Attn: <u>Medical Records</u> Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number (for patient care only): _____																		
FROM: (Where are the records coming from? Fill out completely and legibly.)	Name: _____ Attention: <u>Medical Records</u> Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number (for patient care only): _____																		
Information to be Released (What information and/or dates do you want released? Check appropriate box.)	<p style="color: red;">Indicate Date(s) of Service for the records checked below: _____ or All Dates (If left blank, we will release only the last years' records.)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> All Medical Records</td> <td><input type="checkbox"/> Scans/Ultrasounds</td> <td>Speech Therapy Notes</td> </tr> <tr> <td><input type="checkbox"/> Dictations</td> <td><input type="checkbox"/> Occupational Therapy Notes</td> <td>Most Recent History and Physical</td> </tr> <tr> <td><input type="checkbox"/> Psychotherapy Notes</td> <td><input type="checkbox"/> Progress Notes</td> <td>Lab Reports</td> </tr> <tr> <td><input type="checkbox"/> Operative Reports</td> <td><input type="checkbox"/> Audiology</td> <td>Consultation</td> </tr> <tr> <td><input type="checkbox"/> Sleep Center Results</td> <td><input type="checkbox"/> Xray Reports</td> <td>Pathology Reports</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td><input type="checkbox"/></td> <td></td> </tr> </table>	<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Scans/Ultrasounds	Speech Therapy Notes	<input type="checkbox"/> Dictations	<input type="checkbox"/> Occupational Therapy Notes	Most Recent History and Physical	<input type="checkbox"/> Psychotherapy Notes	<input type="checkbox"/> Progress Notes	Lab Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Audiology	Consultation	<input type="checkbox"/> Sleep Center Results	<input type="checkbox"/> Xray Reports	Pathology Reports	<input type="checkbox"/> Other _____	<input type="checkbox"/>	
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Instructions for Release (How and when is the information needed?)	<p style="color: red;">Date Information Due: _____ (please allow 7 days for completion)</p> <p style="text-align: center;"> <input type="checkbox"/> Paper <input type="checkbox"/> Fax (patient care only) </p>																		
Purpose of Release (Why is the information needed?)	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Continuing Care</td> <td><input type="checkbox"/> Seeing Another Provider</td> <td><input type="checkbox"/> Insurance Claim/Payment</td> </tr> <tr> <td><input type="checkbox"/> Insurance Application *</td> <td><input type="checkbox"/> Personal Use *</td> <td><input type="checkbox"/> Litigation/Legal *</td> </tr> <tr> <td><input type="checkbox"/> Other *</td> <td><input type="checkbox"/></td> <td></td> </tr> </table> <p>* Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. § 164.524</p>	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Seeing Another Provider	<input type="checkbox"/> Insurance Claim/Payment	<input type="checkbox"/> Insurance Application *	<input type="checkbox"/> Personal Use *	<input type="checkbox"/> Litigation/Legal *	<input type="checkbox"/> Other *	<input type="checkbox"/>										
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<ul style="list-style-type: none"> ○ This authorization lasts for one year after the date of signature unless you enter a different date of expiration: _____ ○ This authorization may be canceled in writing at any time ○ KSM will not restrict treatment if you choose not to sign this authorization. ○ A copy of this authorization will be treated in the same way as the original. ○ KSM cannot prevent re-disclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release. ○ Your signature indicates that you have read and understand this form and authorizes the release of your information as indicated above. 																			

Patient /Parent/ Legal Guardian Signature

Date

Authority to act on behalf of patient (attach document)