14135 Cedar Ave So, Suite 100
Apple Valley MN 55124-4523
Phone 952-432-4373
Fax 952-997-5679

Eagan Valley Pediatrics Use Only
MRN _____
Completed By _____
Date _____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	Name:_____DOB:_____ Address:_____ City:_____State:_____Zip:_____ Phone # 1:_____Phone #2_____
Health Information Released **FROM**	◯ Eagan Valley Pediatrics ◯ Other Provider/Person/Organization_____ Address_____ City:_____State:_____Zip:_____
Health Information Released **TO**	Person/Organization: (Please include **COMPLETE** address) _____ _____ ◯ Eagan Valley Pediatrics
Purpose of Disclosure	◯ Transfer of Care ◯ Continuing Care ◯ Insurance ◯ Personal ◯ Legal/Attorney Other(Please Explain)_____
Health Information to be Released	Entire Health Record (includes all records listed) ◯ Office Notes ◯ Laboratory results ◯ Immunization Record ◯ Allergy records ◯ History and physical report ◯ X-ray/Imaging results ◯ Medication information ◯ Behavioral (Mental) Health ◯ Chemical Health Records ◯ Other described here:_____ Unless specifically excluded, behavioral/mental health information, HIV information, and/or alcohol/drug abuse information appearing in the information selected above will be disclosed. **Do not release records/information related to:** O Behavioral/Mental Health O HIV/HIV related illnesses O Alcohol and/or drug abuse **There may be a charge for copies of your records per Minnesota Statue 144.292.**
Method of Delivery	◯Mail to Recipient ◯ Pick up on __/__/__ ◯Fax (Less than 50 pages total) Fax to :_____ATTN: _____ Other:_____
Authorization	•I understand that this consent expires within one calendar year of this date, or shall remain in effect for the period reasonably needed to complete the request for information, whichever date occurs first. **I understand that:** •I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in the FROM section. •Revoking this authorization does not apply to information that has already been released under this authorization. •I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations •I release the above named healthcare provider from all legal responsibility and /or liability that may arise from the release of the records I have specified. I direct that only information prior to the date of my signature be honored and that a photocopy or fax copy of this authorization be granted the same authority as the original. •I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company. _____ _____ Signature of Patient or Patient's Representative Signature Date _____ _____ Print name of Representative Relationship to Patient

evp 2015