NORTH MEMORIAL
Ambulatory Surgery Center
Maple Grove

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information	NAME: _____ DATE OF BIRTH:_____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP: _____
Receiving Party **(WHERE do you want the information sent? WHO may have the information?)**	NAME: _____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP: _____
Information to be Released **(WHAT do you want sent or released? Check all appropriate items that apply.)**	☐ H&P ☐ OR Anesthesia Notes ☐ EKG ☐ PACU Nurse Notes ☐ Lab Reports ☐ Pathology Reports ☐ Doctor Progress Notes ☐ Xray Reports ☐ OR Dictation ☐ Discharge Summary ☐ Discharge Instructions ☐ Other: _____ Reports released may include sensitive information, such as mental status/chemical dependency, HIV/STD, or pregnancy testing results. If there is specific information that you do NOT want released, please write: _____
Purpose of Release **(WHY is it needed?)**	The information is needed for the following purpose: _____
Release Instructions **(HOW and WHEN do you want the information?)**	Date information is needed: _____ (Please allow adequate time for processing.) ☐ Mail ☐ Pickup ☐ Review Only ☐ FAX (_____-_____-_____) ☐ DVD: __mail __pickup) Released by Encrypted Email (address): _____

I understand that once the requested information has been released pursuant to this authorization, we cannot guarantee the continued privacy of the information. The recipient may not be subject to federal and state laws that protect the privacy of health information and might re-disclose the information to additional parties.

I understand that I can revoke this authorization at any time by signing the revocation section of this form and returning it to our facility. We will honor such revocation as soon as we receive it except to the extent we, or other persons allowed to act under the authorization, have already acted in reliance on this authorization.

This authorization will expire once the information requested has been released and received by the designated individual or third party.

I understand that there is no obligation to sign this authorization. In addition, I understand that the ability to obtain treatment, payment, and eligibility for benefits does not depend on whether this authorization is signed except if we are providing health care solely for the purpose of disclosure to a third party.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____
Date Signature of Patient or Personal Representative

_____
Relationship to Patient

REVOCATION SECTION

I hereby revoke this authorization

_____ _____
Signature Date

Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524