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Authorization To Release Medical Records

Patient Name: _____ DOB: _____

Releasing Facility's Information:

_____
_____
_____

Information Needed:

__ Complete Records
__ Most Recent Notes
__ Lab Results/X-ray or MRI Results
__ Progress Notes/H&P/Consults
__ Living Will

Purpose for Release:

__ Attorney Review
__ Insurance Claim Purposes
__ Continued Care by Another Provider
__ Personal Use/Moving Out of the Area
__ Living Will

Patient Rights:

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here: ___.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand hat once information is released pursuant to this authorization, Alexandria Eye Clinic, PA cannot prevent the redisclosure of the information to another third party.

Privacy Notice:

Further use or release of these medical records in individually identifiable form to a person other than the patient without the patient's consent is prohibited by Minnesota law. Minnesota law also requires adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient. If your organization is not in compliance with these laws, please notify use immediately.

Patient Signature: _____ **Date: _____**

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED.