Allergy and Asthma
CENTER OF MINNESOTA

Authorization for Release of Patient Health Information

☐ I Hereby Authorize Allergy and Asthma Center of Minnesota to **REQUEST** information **FROM**:

Clinic Name:______________________________________

Address:____
Street City/State/Zip Code Phone/Fax #

☐ I Hereby Authorize Allergy and Asthma Center of Minnesota to **RELEASE** information **TO**:

Clinic Name:______________________________________

Address:____
Street City/State/Zip Code Phone/Fax #

Regarding the following patient(s):

Patient Name: ____ DOB: _____________

Patient Name: ____ DOB: _____________

Records to be released:

The only records that can be released are records that are generated by Allergy and Asthma Center of Minnesota unless patient was referred:

☐ Entire Record ☐ Other ☐ History & Physical ☐ Laboratory Report ☐ X-Ray Report ☐ Progress Notes

Time period of care to be released: _______________ to _______________
(Please be advised that if you request more than the last four years, requests may take up to two weeks to be processed.)

Purpose of Release:

☐ Continuing care for ongoing treatment ☐ Transfer of Care ☐ Insurance ☐ Personal

Statement of Authorization:
☐ This authorization expires (1) year after the date of my signature below.
☐ I understand that Allergy and Asthma Center of Minnesota will not condition my treatment, payment, enrollment, eligibility, or benefits on my signing this authorization.
☐ Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
☐ I do not authorize further release to any third party. I understand that once information is sent as specified in this authorization Allergy and Asthma Center of Minnesota, and their employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
☐ I understand that if I need to request information on chemical dependency, psychotherapy, and/or HIV/AID testing that a separate release must be completed in order to receive that information.

____
Signature of legally Authorized Representative/Patient Date

____
Print Name Phone # Relationship to Patient

Location
(Please check all locations that the patient has been seen at.)
☐ 2480 White Bear Ave. Ste 104 Maplewood, MN 55109 ☐ 8325 City Centre Dr. Ste 140 Woodbury, MN 55125
☐ 1880 Livingston Ave. Ste. 102 West St. Paul, MN 55118

Please mail all releases to the Maplewood office or fax to 612-888-9247