North Clinic

Colon and Rectal Surgery and Colonoscopy

FAX: (763) 587.7075 OFFICE: (763) 587.7752

Robbinsdale	WEST Health	Maple Grove
3366 Oakdale Ave. N. #215	2855 Campus Dr. #300	9825 Hospital Dr. #300
Robbinsdale, MN 55422	Plymouth, MN 55441	Maple Grove, MN 55369

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT:

Name _____ Age _____

Address _____ Day Phone # _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Health Care Facility/ Provider:

WHO HAS INFORMATION YOU WOULD LIKE RELEASED?

Name _____ Department _____

Address _____

City _____ State _____ Zip _____

Requestor:

TO WHOM SHOULD THE INFORMATION BE SENT?

Name _____ Fax: _____

Address _____

City _____ State _____ Zip _____

Information to be Disclosed:

MEDICAL RECORD RELEASE

- ❑ Clinic visit notes (including records related to HIV, mental health, alcohol and/or drug treatment)
- ❑ Consultation/Follow-up Reports
- ❑ X-Ray Reports
- ❑ Psychological Testing/Report
- ❑ EMG Report
- ❑ EKG Report
- ❑ Special Tests
- ❑ Lab Reports
- ❑ Hospital Reports
- ❑ Other (Specify) _____

RADIOLOGY FILM RELEASE

- ❑ *Original X-Ray of _____ ❑ Mailed date _____
- _____ ❑ Pick up date _____
- ❑ X-Ray copies of _____ by _____
- _____ **(fees are applied for copies of films)**
- ❑ Permanent Transfer of Mammograms *Return loaned films within 30 days

Reason for the Release:

- ❑ Insurance change
- ❑ Consult/Second Opinion
- ❑ Insurance Claim Report
- ❑ Personal **(fees are applied for records requested beyond 1 year)**
- ❑ Out of Town Move
- ❑ Selected New Non-NC MD
- ❑ Legal
- ❑ Other

Revocation:

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when North Clinic receives my notice in writing. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.

Authorization:

I hereby authorize North Clinic, PA, to disclose medical information concerning the above-named patient to the party identified in the section entitled "Requestor". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Patients Signature* _____ Date _____

If other than patient, please state relation: _____

* Anyone 18 years old or older must sign for themselves.

This authorization complies with HIPPA Privacy Rule. A photocopy or fax of this authorization shall have the same effect as the original signature.