

**Mendakota Pediatrics, Ltd.**

1880 Livingston Avenue Suite 102 West St Paul, MN 55118  
(651) 552-7999 Fax: (651) 552-0777

Date: \_\_\_\_\_

Page: #1

**Patient Information**

For: \_\_\_\_\_ Patient Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

**Authorization to Release Protected Health Information**

Patient ID#	Name	Birth Date
-------------	------	------------

Instructions: If any section is incomplete, this form may be invalid and the request cannot be processed.

Release information From:

Release information To:

Name: \_\_\_\_\_  
 Attn: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mendakota Pediatrics, Ltd.  
 1880 Livingston Ave., Suite 102  
 West Saint Paul, MN 55118  
 Phone: 651-552-7999  
 Fax: 651-552-0777

**Purpose of Release**

<input type="checkbox"/> Treatment/continued Care	<input type="checkbox"/> Personal	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Payment of Insurance Claim
<input type="checkbox"/> Other		

**Information to be Released**

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Laboratory Records
<input type="checkbox"/> X-Rays	<input type="checkbox"/> Clinic Notes	
<input type="checkbox"/> Other		

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. If I don't want these to be released, I will place a checkmark here:  I don't want the following records released: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Mendakota Pediatrics. I understand that stopping this authorization will not apply to information that has already been released or disclosed. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: \_\_\_\_\_

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
 

<input type="checkbox"/> Legal Guardian or Conservator	<input type="checkbox"/> Health Care Agent
--------------------------------------------------------	--------------------------------------------
- If the patient is 17 years of age or younger, the patients parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship.
 

<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian
---------------------------------	-----------------------------------------

<b>Signature (Required)</b>	<b>Date Signed (Required) (Month DD, YYYY)</b>
Printed Name of Person Signing (If Not Patient)	
Mailing Address of Patient	Phone