Comprehensive Health Clinics

236 2nd Avenue SW, Cambridge, MN 55008
(763) 689-2462
Fax (763) 689-1688

# Patient Authorization for Release of Information - Incoming

| | | |
|---|---|---|
| **Patient:**<br>**Please Print** | **Name:** | **Date of Birth:** |
| | **Address:** | **Phone:** |
| | **City, State, ZIP:** | |
| **Health Care Facility/Provider** | **WHO HAS THE INFORMATION YOU WOULD LIKE RELEASED?** | |
| | **Facility Name:** | **Fax:** |
| | **Address:** | **Phone:** |
| | **City, State, ZIP:** | |
| **Requesting Party** | **WHO SHOULD RECEIVE THE INFORMATION?** | |
| | **Facility:**<br>Comprehensive Health Clinics | **Attention:** |
| | **Address:**<br>236 2nd Avenue SW | **Fax:**<br>763-689-1688 |
| | **City, State, ZIP:**<br>Cambridge, MN 55008 | **Phone:**<br>763-689-2462 |
| **Information to Be Disclosed** | ___Clinic Notes<br>___ Radiology Reports (Fax)<br>___ Radiology CD<br>___ Hospital/Operative Reports | ___ EKG/EMG Reports<br>___ Lab Reports<br>___ Other: _____ |
| **Reason for Disclosure** | ___ Continuing Care<br>___ Physician Consultation<br>___Personal | ___Attorney<br>___ Insurance Company (fee) |
| **Revocation** | I understand that my signature is valid for up to one year from the date signed below. I understand that I can request, in writing, cancellation of the authorization at any time. I do not authorize re-release of this information to anyone. A copy of the authorization is valid as the original. I understand that once Comprehensive Health Clinics has disclosed health care information I have authorized, Comprehensive Health Clinics has no control over the information and may no longer be protected by privacy laws. Comprehensive Health Clinics will not condition treatment for any patient that refused to sign an authorization for release of Protected Health Information. | |
| **Authorization** | **I AUTHORIZE THE ABOVE PROVIDER TO RELEASE THE INFORMATION DESIGNATED TO THE REQUESTOR** | |
| | **Patient/Guardian Signature:** | **Date:** |
| | **Relationship to the Patient:** | **Reason Patient is Unable to Sign:** |

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