



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

Patient Authorization for Release of Information - Incoming

Patient: 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: Comprehensive Health Clinics	Attention:
	Address: 236 2 nd Avenue SW	Fax: 763-689-1688
	City, State, ZIP: Cambridge, MN 55008	Phone: 763-689-2462
Information to Be Disclosed	☐ Clinic Notes ☐ EKG/EMG Reports ☐ Radiology Reports (Fax) ☐ Lab Reports ☐ Radiology CD ☐ Other: _____ ☐ Hospital/Operative Reports	
Reason for Disclosure	☐ Continuing Care ☐ Attorney ☐ Physician Consultation ☐ Insurance Company (fee) ☐ Personal	
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: