

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

My Information should be released FROM:(select only one)

Boynton Health (address/FAX above)

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

My Information should be released TO: (select only one)

Boynton Health (address/FAX above)

Name: Disability Resource Center
 Address: 180 McNamara Alumni Ctr, 200 Oak Street SE
 City: Minneapolis State: MN Zip: 55455
 Phone: 612-626-1333 Fax: 612-626-9654

Patient Identifying Information:

Name (Please print): _____
 Date of Birth: _____
 Patient #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Work: _____

How to Release (select only one):

Mail the information to the address written above.

Fax the information to the fax number written above.

I or _____ (valid photo ID required) will pick up the records on _____. Allow one week unless other arrangements are made.

Other (specify): BOX

I authorized the release of:

Printed copy of my records. Form(s) and/or Letter(s).

Other (explain) : _____

Verbal exchange of information between parties.

The purpose of this release is: Continuing care. Other: _____

Information to be released: (select all that apply)

Specific Visit, Date(s)/Condition(s): _____

Clinical records: (specify)

<input type="checkbox"/> Clinic/Progress notes	<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Laboratory/Pathology records	<input type="checkbox"/> Eye Clinic Notes
<input type="checkbox"/> Immunizations.	<input type="checkbox"/> TB screening	<input type="checkbox"/> HIV/AIDS treatment	<input type="checkbox"/> EKG reports
<input type="checkbox"/> Dental Clinic records	<input type="checkbox"/> Dental xrays	<input type="checkbox"/> Psychiatric records	<input type="checkbox"/> Chemical Dependency Treatment

Other: Accomodation letter

These records require specific consent for release and may not be combined with any other consent on the same page:

Psychotherapy notes. Couples/Family Therapy - **Each party must complete a separate form.**

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization will expire one year from the date of my signature unless a different expiration date is entered here:** _____
- I understand that once information is released pursuant to this authorization, Boynton Health cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- I understand that my treatment will not be conditioned on my signing this authorization except for research-related treatment.
- I understand that I am entitled to a copy of this *Authorization for the Release of Health Information*.

Signature of Patient/Authorized Person _____

Authorized Person's authority to sign _____

Date _____

Printed name of Authorized Person _____

REASON PATIENT CANNOT SIGN: Minor Deceased Other: _____

OFFICE USE ONLY

Fee	Received by: _____	Completed by: _____
	Filed by: _____	Date sent: _____

rev 04/26/18