Location:	Crystal	Maple Grove	Osseo	Plymouth
Fax #	763-587-7989	763-494-7501	763-420-1901	763-587-7701

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Previous Name: _____ DOB: _____

I hereby authorize: _____
NAME OF HEALTHCARE PROVIDER PHONE NUMBER

To release my records to: _____ _____
NAME ADDRESS

_____
CITY ZIP CODE PHONE # FAX #

The disclosure is being made for the following purpose(s)	
❑ Diagnosis & Treatment	❑ Legal
❑ Insurance/Billing	❑ Other:
❑ Personal	

I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

Information to be released:	**Date of Service***	**Information to be released:**	**Date of Service***
❑ Pertinent Records of Continuing Care	_____	❑ Radiology Reports	_____
❑ Discharge Summaries	_____	❑ Radiology Films	_____
❑ History & Physical	_____	❑ OB/GYN Records	_____
❑ Clinic Notes (2 yrs)	_____	❑ Pediatric Records	_____
❑ Consultations	_____	❑ Immunizations	_____
❑ Pathology Reports	_____	Other: _____	_____
		_____	_____

*If a date of service is not listed, Voyage Healthcare will release information going back 2 years only.

Authorization of Release of the Indicated Records below requires patient's initials:

	Patient's initials		Patient's initials
❑ HIV or AIDS		❑ Chemical Dependency	
❑ Psychotherapy/Mental Health		❑ Other:	

I release the above-named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified. 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 Voyage Healthcare 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. 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 eligibility for benefits.

Patient/Representative Signature _____ **Date** _____

Representative Name (if applicable) _____ **Relationship** _____

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