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

Date:

Patient information for (Patient Name):

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:

Name:_____

Attn:_____

Address:_____

City:_____ State_____ Zip_____

Phone:_____ Fax_____

Release Information To:

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

Purpose of Release

- ☐ Treatment/Continued Care
- ☐ Application for insurance
- ☐ Other
- ☐ Personal
- ☐ Disability
- ☐ Legal Purposes
- ☐ Payment of insurance Claim

Information to be released

- ☐ History and Physical
- ☐ Radiology
- ☐ Other
- ☐ Immunization Records
- ☐ Clinic Notes
- ☐ Laboratory

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 re-disclosure 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 la 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:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent
- If the patient is 17 years of age or younger, the parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship.
  ☐ Parent ☐ Legal Guardian

Signature *{Required}*	Date Signed *{Required} (Month DD,* YYYY)
Printed Name of Person Signing *(If not Patient)*	
Mailing Address of Patient	Phone

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