

# Adefris & Toppin Women's Specialists

1875 Woodwinds Drive Suite 110 Woodbury, MN 55125

Phone # 651-686-6400 Fax # 651-714-1264

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Chart # \_\_\_\_\_

Previous Name(s) \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This will authorize Adefris & Toppin Women's Specialists to request information **FROM**:

This will authorize Adefris & Toppin Women's Specialists to release records **TO**:

Name/Organization		
Street Address		
City	State	Zip Code
Phone #	Fax #	

### Please choose from the following information to be released:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> History & Physical Exam(s) | <input type="checkbox"/> Operative Report        | <input type="checkbox"/> Lab Reports             |
| <input type="checkbox"/> Clinic Notes               | <input type="checkbox"/> Pathology Reports       | <input type="checkbox"/> Emergency Dept. Reports |
| <input type="checkbox"/> Hospital Notes             | <input type="checkbox"/> X-Ray/Radiology Reports | <input type="checkbox"/> Psychological Tests     |
| <input type="checkbox"/> Consultation Reports       | <input type="checkbox"/> Ultrasound Reports      | <input type="checkbox"/> Other _____             |
- All records (of the releasing facility AND records dating back 2 years only)

For the following date(s) of treatment or condition: \_\_\_\_\_  
(please specify dates of treatment or condition)

### I am requesting this information for use by:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Medical Personnel/Facility | <input type="checkbox"/> Insurance Company     | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Attorney                   | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other _____  |

### Please indicate your reason for the transfer:

- Moving  Insurance Change  Dissatisfaction  Primary Physician  Convenience of Location

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing **will be released unless** initialed here \_\_\_\_\_. Please indicate specific restrictions. \_\_\_\_\_
- I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.
- This authorization **will automatically expire one year from the date of my signature** unless I indicate an earlier date here \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I understand that I may refuse to sign this authorization. I need not sign this authorization to ensure treatment.
- I understand **there will be a retrieval/copy charge for medical information requested that's older then 2 years from this release.**
- I understand that once information is released pursuant of this authorization, Adefris & Toppin Women's Specialists can not prevent the re-disclosure of that information to any third party.
- **I understand this authorization must be filled out completely and signed in order to be considered valid.** A copy that has not been altered will be considered as valid as an original.

\_\_\_\_\_  
**Signature of Patient/Authorized Person**      **Relationship to Patient**      **Date**  
REASON PATIENT IS UNABLE TO SIGN:  Minor  Deceased  Other: \_\_\_\_\_