Adefris & Toppin Women's Specialists
1875 Woodwinds Drive Suite 110 Woodbury, MN 55125
Phone # 651-686-6400 Fax # 651-757-3265

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:

☐ History & Physical Exam(s) ☐ Operative Report ☐ Lab Reports
☐ Clinic Notes ☐ Pathology Reports ☐ Emergency Dept. Reports
☐ Hospital Notes ☐ X-Ray/Radiology Reports ☐ Psychological Tests
☐ Consultation Reports ☐ Ultrasound Reports ☐ 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:

☐ Medical Personnel/Facility ☐ Insurance Company ☐ Personal Use
☐ Attorney ☐ Worker's Compensation ☐ Other _____

Please indicate your reason for the transfer:

☐ Moving ☐ Insurance Change ☐ Dissatisfaction ☐ Primary Physician ☐ Continuing Care (NOT transferring)

- 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:_____