Southdale Pediatric Associates, Ltd.
PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Release from:

_____
Clinic

_____
Address

_____
City State Zip

Release to:

_____
Clinic

_____
Address

_____
City State Zip

Please release the indicated information on the following patients:

1. _____ Date of Birth _____
2. _____ Date of Birth _____
3. _____ Date of Birth _____
4. _____ Date of Birth _____

Parent Names (If applicable) _____
Address _____
Street City State Zip
Phone Number: _____
Reason for transfer: _____
Information to be released from: _____ To: _____

CURRENT RECORDS (Previous 2 years) - NO CHARGE
FOR ADDITIONAL - SEE CHARGE FOR COPIES BELOW

_____Progress Records
_____Lab Data
_____X-Ray reports
_____Immunization Record
_____Consultation Reports
_____Hospital Reports

_____Treatment & Evaluation for Mental health
_____Treatment & Evaluation for Chemical Dependency
_____Testing & Treatment for HIV
_____Treatment for Sickle Cell Anemia

This authorization does not include the release of records concerning: _____

Charge for Copies:
Requests for copies of **CURRENT MEDICAL RECORDS (PREVIOUS TWO YEARS)** generated by Southdale Pediatric Associates, Ltd. for personal use or to be sent to another physician will be **PROVIDED AT NO CHARGE**.

Copies of **COMPLETE MEDICAL RECORDS** will be provided at a rate consistent with Minnesota statute 144.335 subdivision 5 which, updated annually, computes maximum charges. For rates, visit the website at www.health.state.mn.us/divs/hpsc/dap/notices.html. Click on maximum charge for copies of patient records.

I understand that I may revoke this consent at any time in writing and that upon fulfillment of the above stated purpose, or six months from this date (which ever occurs first), this consent will automatically expire without my express revocation. If complete copies are requested, we will notify you regarding the total charge prior to copying.

_____ _____
Signature Date

_____ _____
Relationship to Patient Reason Patient Unable to Sign

_____
Witness