



MyMedicalClinic
High quality healthcare from our doctors to you

AUTHORIZATION OF RELEASE FOR PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

I authorize the release of my protected health information as follows:

- All my records including all general health records, medical histories, examination and treatment notes, radiology and laboratory test results, consultation and referral notes, etc.
- My records related to treatment for (specific illness, injury, evaluation or date of service): _____

Other records (please describe): _____

I FURTHER AUTHORIZE THE RELEASE OF THE ADDITIONAL INFORMATION BELOW

- HIV/AIDS RELATED INFORMATION
- DRUG/ALCOHOL TREATMENT
- INPATIENT MENTAL HEALTH RECORDS
- PSYCHOTHERAPY NOTES
- STD INFORMATION
- OTHER: _____

RECORDS RELEASED FROM: My Medical Clinic

Other Clinic or Physician: _____

RECORDS RELEASED TO:

My Medical Clinic - 1560 Beam Ave, Suite F, Maplewood, MN 55109
Phone: (651) 340-1455 Fax: 651-340-5421

Other Clinic or Physician: Clinic name, Physician and full address: _____

PURPOSE (CHECK ALL THAT APPLY):

- Insurance Eligibility/Benefits
- Further Medical Care
- Personal at my request
- Other: _____
- Legal Investigation/Action
- Clearance for Work Exam

EXPIRATION: This authorization is good until the following date: ____/____/____

* If this item is left blank, the authorization will expire in one (1) year from the date signed

Your rights in connection with this authorization

I can ask for a copy of the protected health information that will be disclosed. A processing and/or copying charge may apply as permitted by law. I may revoke my authorization at anytime, but I must do so in writing to the clinic where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. I understand that my health information may not be protected from further disclosure by some entities receiving my information under this authorization, and that My Medical Clinic has no control over subsequent disclosures by other entities.

Printed Patient or Guardian Name Self Parent or Legal Guardian

Patient or Guardian Signature Date: _____