



AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION



Pediatric and Adolescent CarE of MN
1547 Livingston Ave N
West Saint Paul MN 55118

Phone: 651-451-8050
Fax: 651-552-1575

Patient Name: _____ Date of Birth: _____

I authorize:			To release to:		
_____			_____		
Name			Name		
_____			_____		
Address			Address		
_____			_____		
City	State	Zip	City	State	Zip
_____	_____	_____	_____	_____	_____
Phone#	Fax#		Phone#	Fax#	
_____	_____		_____	_____	

This information is being released at the request of the individual for the following purpose:
 Continuation of Care Insurance Claim Litigation Other _____
 Verbal Release of Information Only

Please check or specify all requested information below.
Information is routinely copied for the previous three years. If older information is needed, please specify those dates below.

Immunizations Only X-ray Mental Health records History and Physical only
 Clinic Visits (includes previous three years visits, growth chart and immunizations)
 Other _____ Dates of service _____

I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, acquired immunodeficiency disorder (AIDS), and/or human immunodeficiency virus (HIV). 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 a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing. I understand that stopping this authorization will not apply to that has already been released or disclosed.

I understand 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 disclosures of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

Unless otherwise revoked, this authorization will expire in one year.

_____	_____	
Signature of Parent/Guardian/Patient	Date Signed	
_____	_____	
Address	Phone#	
_____	_____	
City	State	Zip
_____	_____	_____

Relationship to Patient: Mother Father Patient Other _____

Staff Initials: _____ ID Verified: Yes

