Authorization for Release of Confidential Medical Information

Northland Plastic Surgery

4316 Rice Lake Rd. Ste 109
Duluth, MN 55811

_____ _____/_____/_____

Patient Name: Last First Date of Birth

I hereby authorize:
(Name and Address of releasing facility)

_____
_____
_____
_____

To Release Information To:
(Individual name, facility/organization and address)

_____
_____
_____
_____

EXTENT OF INFORMATION TO BE SENT:

Including all dates of treatment

Between the dates of _____ to _____

Other: _____

PURPOSE OF DISCLOSURE:

_____ Continuing care
_____ Claim payment
_____ Legal
_____ Personal

TO INCLUDE FINDINGS AND RESULTS OF:

Physician notes
X-ray reports
X-ray films
Laboratory reports
Diagnostic test reports

_____ Photos
_____ All available records
_____ Other (Please specify)
_____
_____

I UNDERSTAND:

- the expiration of this authorization is one year.
- that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- by authorizing this use or disclosure of information, there will be no conditions placed on my healthcare or payment for my healthcare.

_____ _____

SIGNATURE OF PATIENT, PARENT OF MINOR, OR PERSONAL REPRESENTATIVE RELATIONSHIP DATE