AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____ Date of Birth: _____

Phone #: _____ MRN:_____

RELEASE INFORMATION FROM:

_____

_____

RELEASE INFORMATION TO:

St. Cloud Pediatrics

3290 42nd Ave S

Suite 100

St. Cloud, MN 56301

Phone: 320-227-5010

Fax: 320-227-5012

Preferred Method:

Print:____ Fax:_____

RELEASE CONTENT: only information checked will be released

Dates of Service:_____

Face sheet	Path Report	Lab	Other
Discharge Sum	ED record	X-ray	Billing Record
H&P	Progress Notes	EKG	
Op Note	Nursing Notes	Stress test	
Proc Note	PT/OT/Speech Notes	Echocardiogram	

SENSITIVE MATERIAL: I authorize release of information about the following sensitive information if it is contained within the medical record: (if your entire medical record is being released, check those pieces of highly sensitive health information you authorize released):

HIV test results

Alcohol and Drug abuse records

Sexually Transmitted Diseases

Psychiatric information

Other: List of specific items: _____

RELEASE FOR DISCLOSURE: My health information is being released or disclosed for the following reasons:

Personal

Other: _____

Continuation or Transfer of Care

I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by notifying Simplicity Health in writing. This authorization will expire one year from the date of signature unless otherwise indicated _____ .

Signature of patient/parent: _____ Date:_____ Print name of patient:_____