RELEASE OF INFORMATION AUTHORIZATION FORM

Leap
Pediatric and Adolescent Care

Authorization to Release Health Information

Patient Information:	Name: _____ Date of Birth: _____ Alias: _____ SSN: _____ Phone: _____ MRN: _____
Health Information Released FROM:	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ Fax: _____ Phone: _____
Health Information Released TO:	Leap Pediatric and Adolescent Care 450 Syndicate St. N. Suite 250 Saint Paul, MN 55104-4017 Fax: 651-350-3582 Main clinic phone number: 651-350-3580
Health Information to be Released:	Date(s) of Service: _____ Type of Visit: _____ ☐ History and Physical ☐ Photographs ☐ Radiology Reports ☐ Laboratory Reports ☐ Discharge Summary ☐ Radiology Images (not able to fax images) ☐ Emergency Room Report ☐ Progress/Clinic Notes ☐ Dental Report/X-rays ☐ Surgery Report ☐ Care Plan ☐ Visits Report ☐ Medications ☐ Immunizations ☐ Cardiac/EKG Reports ☐ Other (Must specify. 'ALL' will not be accepted): _____ All information regarding alcohol/drug use or abuse, mental health and/or HIV/AIDS WILL BE RELEASED unless you tell us NOT to by initialing below: _____Do not release Alcohol/Drug Use or Abuse records. _____Do not release HIV/AIDS records. _____Do not release Mental Health records.
Form or Format of Release:	☐ Hard Copies (paper) ☐ Electronic (examples include CD & email) See #5 on instructions for more details regarding electronic releases and risks ☐ Verbal Exchange (no copies) ☐ Review of Record (no copies)
Purpose of Release:	☐ Personal ☐ Attorney ☐ Continued Care - Appt Date: _____ ☐ Insurance ☐ Disability/ Social Security ☐ Other: _____ There may be a charge/fee for copies of records.
Delivery Method:	☐ Mail ☐ Fax ☐ Pick up by patient/authorized designee (requires photo ID) ☐ Email - Email address:

Authorization/ Revocation	This authorization will terminate in one year unless otherwise specified: _____ I understand that I may stop this release at any time by writing to Leap Pediatric and Adolescent Care. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Leap Pediatric and Adolescent Care will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X_____ X_____ Signature (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date X_____ Relationship to patient (if not patient) NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. A photocopy of this authorization is as valid as the original.
Staff Use Only	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____

Health Information Management – Release of Information, 450 Syndicate St. N Suite 250, St. Paul, MN 55104 | Phone: 651-350-3580 | Fax: 651-350-3582

To protect our patient's confidential medical information, we must have a valid, complete and legible authorization to disclose their health information.