



All About Children Pediatrics, P.A.

Phone: 952-943-8200

Fax: 952-943-8206

www.allaboutchildren.net

# Medical Records Release Authorization

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_  
(Full legal name)

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Work \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

**A) I hereby Authorize records FROM:**

(physician/practice releasing/sending information)

Practice/Doctor Name: All About Children Pediatrics, P.A.

Address: 12200 Middleset Road, Suite 100

City/State/Zip: Eden Prairie, Minnesota, 55344

Phone# (952) 943-8200 Fax# (952) 943-8206

**B) To send information TO:**

(physician/practice or person receiving the information)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

**For the Purpose of (check all that apply):**

- Switching clinics
- Moving out of state or country
- Specialist/Consultation
- Insurance related
- Legal request
- Personal Use
- Other (specify) \_\_\_\_\_

**Date Range:**

\_\_\_\_\_ to \_\_\_\_\_

**Copy Form:**

- On usb flash drive (1 time)
- Printed copy (see \*Fees)
- Fax to: \_\_\_\_\_

**Initial to indicate the information to release:**

- Entire Chart (any/all medical records)
- Health Summary Only
- Immunization Records
- Lab/Pathology Reports
- Radiology/X-Ray/MRI Reports
- Specialist Reports \_\_\_\_\_
- Other (be specific) \_\_\_\_\_

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_  
(Expiration date of authorization)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative) **\*Subject to Fees**

**\*Fee Information:** For continuity of care, All About Children Pediatrics will electronically transfer a reasonable portion of your medical records directly to a physician and/or medical practice as a courtesy. If requesting entire chart records, All About Children will provide and/or send one copy on electronic media as a courtesy. In the case of printed copy requests, we reserve the right to charge the fee schedule as set by the State of Minnesota Statute 144.292. A \$17.96 handling fee, \$1.35 cents per page and postage will be invoiced to you. By signing this authorization, you are agreeing to pay All About Children Pediatrics for any printed copies and/or additional electronic copies of your records.



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