Adefris & Toppin Women's Specialists, M.D.P.C.
CityPlace Medical II 215 Radio Drive, Suite 200 Woodbury, MN 55125
Phone # 651-686-6400 Fax # 651-757-3265

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:		**Chart #:**
Previous Name(s):	**Last 4 digits SS #:**	**Birth Date:**
Home #:	**Work #:**	**Cell #:**

☐ **This will authorize Adefris & Toppin Women's Specialists to request information FROM**:

☐ **This will authorize Adefris & Toppin Women's Specialists to release information TO**:

Name/Organization:		
Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	

Please choose the information to be released:

☐ History & Physical Exams ☐ Operative Reports ☐ Ultrasound Reports ☐ Radiology Reports
☐ Clinic Notes ☐ Pathology Reports ☐ Emergency Dept. Reports
☐ Hospital Notes ☐ Lab Reports ☐ Consultation Reports ☐ Others ___________
☐ All records (of the releasing facility AND records dating back 2 years only)

For the following date(s) of treatment or condition only:____
(Please specify dates of treatment or condition)

I am requesting this information for use by:

☐ Medical Personnel/Facility ☐ Insurance Company ☐ Personal Use
☐ Attorney ☐ Worker's Compensation ☐ Other ________________

Please indicate the purpose/need for this information:

☐ Continuing Care (NOT transferring) ☐ Dissatisfaction ☐ Insurance Change
☐ Primary Physician ☐ Transferring Care ☐ Other ________________

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing **will be released unless** initialed here _______. Please indicate specific restrictions. ____
- I understand I may revoke this authorization at any time, by written request. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.
- This authorization **will expire one year from the date of my signature** unless I indicate an earlier date here ___/___/___.
- I understand that I may refuse to sign this authorization. I do not need to sign this authorization to ensure treatment.
- I understand **there will be a retrieval fee for medical information requested that is older than 2 years from this release.**
- I understand that once information is released in response to this authorization, Adefris & Toppin Women's Specialists cannot prevent the re-disclosure of information to any third party.
- **I understand this authorization must be filled out completely and signed in order to be considered valid**. A copy that has not been altered may be considered as valid as an original.

________________________________ ________________________________ ________________________

Signature of Patient/Authorized Person Relationship to Patient **Date**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor Deceased ☐ Other ____