Adefris & Toppin Women's Specialists
Obstetrics, Gynecology and Infertility

Internal Use Only | Account #_____
Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:	
	DOB: / /	PREVIOUS NAME(S):
2. RELEASE MY RECORDS FROM	FACILITY NAME:	
	DR. NAME:	
3. SEND MY RECORDS TO	NAME:	ATTN TO:
	ADDRESS:	
	CITY:	STATE: ZIP:
	PHONE:	FAX (For Continuing Care ONLY):
	UPCOMING APPT DATE: ___ / ___ / _____	
4. TYPES OF RECORDS	BODY PART:	
	DATE(S) OF SERVICE:	
	☐ All Health Records (not including billing or imaging) ☐ Billing Statement ☐ Lab Reports ☐ Office Notes ☐ Operative Note ☐ Other_____	
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____	
	"Verbal disclosure" authorizes Adefris & Toppin Women's Specialists to discuss my care with the person(s) indicated in this section:	
6. REASON FOR REQUEST	☐ Continuing Care ☐ Insurance ☐ Personal Use ☐ Disability ☐ Legal ☐ Workers Compensation	
	Do you need patient photos? ☐ Yes ☐ No	
7. RETURN COMPLETED FORMS TO:	**MAIL TO:** Adefris & Toppin Women's Specialists 215 Radio Drive #200 Woodbury, MN 55125	**FAX TO:** 651-757-3265 **DROP OFF:** At Adefris & Toppin Women's Specialists
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.	
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicted above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form. SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.	

Rev-12/19

Electronic or Typed Signatures cannot be accepted