

Adefris & Toppin Women's Specialists
 An Operating Division of Infinite Health Collaborative (i-Health)
 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:	Date of Birth:
Previous Name(s):	Last 4 digits SS #: Chart #:
Home #:	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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> History & Physical Exams | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Ultrasound Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Dept. Reports | |
| <input type="checkbox"/> Hospital Notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> 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:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Medical Personnel/Facility | <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other _____ |

Please indicate the purpose/need for this information:

- | | | |
|---|--|---|
| <input type="checkbox"/> Continuing Care (NOT transferring) | <input type="checkbox"/> Dissatisfaction | <input type="checkbox"/> Insurance Change |
| <input type="checkbox"/> Primary Physician | <input type="checkbox"/> Transferring Care | <input type="checkbox"/> 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: <input type="checkbox"/> Minor <input type="checkbox"/> Deceased <input type="checkbox"/> Other _____		