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: | PHONE: | FAX: |
| **3. SEND MY RECORDS TO** | NAME: | ATTN TO: | |
| | ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX (For Continuing Care ONLY): | |
| | Email:<br>(Only if you want records sent via encrypted email) | | |
| **4. TYPES OF RECORDS** | DATE(S) OF SERVICE: | | |
| | ☐ All Health Information (not including billing)<br>☐ Office Notes<br>☐ Radiology Reports | ☐ Lab Reports<br>☐ Operative Reports<br>☐ Hospital Reports<br>☐ Billing Statement | ☐ Pathology Reports<br>☐ Other: |
| **5. REASON FOR REQUEST** | ☐ Personal Use<br>☐ Disability | ☐ Insurance<br>☐ Legal | ☐ Workers Compensation<br>☐ Continuing Care |
| **6. RETURN COMPLETED FORMS TO:** | **MAIL TO OR DROP OFF:**<br>Adefris & Toppin Women's Specialists<br>215 Radio Drive, Suite 200<br>Woodbury, MN 55125 | **EMAIL TO:** atwsOffice@adefrisandtoppin.com<br>**FAX TO:** 651 – 757 – 3265 | |
| | * Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing. | | |

**7. I UNDERSTAND THAT BY SIGNING THE BELOW:**

- I may revoke this authorization at any time by notifying i-Health in writing. If I revoke this authorization, i-Health will no longer use or disclose my health information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization.
- By authorizing the release of my protected health information, the health information may no longer be 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 from any i-Health facility, unless otherwise specified 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 this form, unless specified here: _____
- If I provided an email address in section 3, I understand that the requested records will be sent via encrypted email, or it may be sent to a patient portal.
- i-Health is a multispecialty practice including, and without limitation, the clinic above. Your i-Health record will be released, unless you otherwise specify in writing

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.



***Electronic Typed Signatures cannot be accepted***