Advanced Specialty Associates
13359 Isle Drive Suite 1
Baxter, MN 56425
Phone: 218-454-8888 Fax: 888-835-7231
Kurtis Waters MD ● Daniel Schneider MD ● Philip Manger MD● Katie Starns NP

Patient 's Authorization for Use or Disclosure of Protected Health Information

1. Patient Information	Name: ___________________________ Date of Birth: _______________ Address: __________________________Phone number: _______________
2. Health Care Provider or clinic/hospital who has the information you want released?	Name/Organization: _______________________________ Phone Number: ___________________ Fax Number: ________________ Address: ________________________________City: ___________ State: ______Zip:________
3. Where do you want the information to be sent?	Name/Organization: _______________________________ Phone Number: ___________________ Fax Number: ________________ Address: _________________________________City: ___________ State: ______Zip______
4. Why is it needed?	□ Continuing Care □ Workers' Compensation* □ School □ Personal Use* □ Insurance Claim* □ Legal* □Insurance Application* □ Other ________________________
5. What are the approximate dates of information you want released? What do you want released? Choose Routine for items a health care provider typically needs or select individual records.	Service Dates Between ____________ to _____________________ Send All Routine Records: □ Notes, History and Physical, Discharge Summary, Emergency Room, Lab, Radiology, Procedures, Test Results and Consultations Or Send Other Records: □ Discharge Summary □Diagnostic Test Results □ Consultations □ Imaging Films □ Radiology Reports □History & Physical Exams □ Pathology reports □ Lab Results □Op/procedure reports □ Pathology Slides □ Billing Records □ ER Records □ Other: _______________________
6. When is the information needed?	Date the information is needed _____________ (please allow 5-7 days for processing) If needed for appointment, what is the date of appointment? ________________
7. How do you want the information?	Release Method/Format Requested: □ Pick up (photo id required) □ Mail □ Fax □ CD/DVD

Revised 05/2020

	• This authorization lasts for one year after the date you sign it unless you enter a different expiration date here: _______________. • I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it. • I understand that information used or disclosed pursuant to this authorization may be subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. • I understand that Advanced Specialty Associates may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. • I understand, upon request, I will receive a copy of this form after I have signed it. • I understand that in compliance with MN Statute 144.293 NDCC 23-12-14, Federal Rule 45 CFR 164.524; charges may apply in ID. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. • I understand a photocopy or fax of this form is the same as the original.
8. Patient Signature and date are required to release records. If an Authorized person is signing you must include legal documentation.	________________________ Patient Signature Date: ________________________ Signature of Authorized Person □ Parent of Minor □ Court-appointed guardian/conservator