APPLE VALLEY MEDICAL CLINIC, LTD.

at APPLE VALLEY MEDICAL CENTER ...On Galaxie

Authorization to Release Protected Health Information

Section 1: Patient Information

Patient's Name: (First Name, Last Name):	
Date of Birth:	Phone Number:
Address:	City, State, Zip:

Section 2: Sender's & Recipient's Information

Sender's Name:_____ Sender's Address:_____ Sender's City, State, Zip: _____ Sender's Phone Number: _____ Sender's Fax Number: _____	**Release Information To:** **Apple Valley Medical Center** 14655 Galaxie Avenue Apple Valley, MN 55124 Phone: (952) 432-6161 Fax: (952) 432-7019

Section 3a: Types of PHI to be released:

☐ Any and All Information
☐ History and Physical
☐ Progress/Clinic Notes
☐ Exam Notes
☐ Laboratory Results
☐ Immunization/Allergy Records
☐ Radiology Images
☐ Billing Records
☐ Other Information _____

Dates of Service: _____

Section 3b: Specific PHI to be released:

The following information below is protected by law and will not be released unless you specifically authorize the release of the information, even if you indicate Any and All Information.

☐ Drug / Alcohol Treatment Records
☐ Mental Health (other than psychotherapy notes)
☐ HIV Test Results
☐ Genetic Testing Information

Section 4: Purpose of Disclosure:

☐ Patient's Request/Personal
☐ Continuity of Care / Visit with another Provider
☐ Legal
☐ Disability Determination
☐ Insurance Purposes
☐ Marketing Purposes (payment or compensation involved?) Yes or No. If yes, How much_____
☐ Sale (Payment or compensation to entity maintain the information?) Yes or No. If yes, How much_____
☐ Other (Please Explain)_____

Section 5: Purpose of Disclosure:

Format:

☐ Paper:
☐ Electronic:
☐ Unencrypted E-mail
  ○ E-mail Address: _____

Delivery Method:

☐ Mail
☐ Pick up at Clinic
☐ Unencrypted E-mail**

*** Only for Patient / Personal Requests*

Patient Name: _____ DOB:_____

Section 6: Authorization Expiration:

I understand that this Authorization will expire one year (12 Months) from the date the form is signed unless otherwise specified as follows _____ (MM/DD/YYYY)

Section 7: Patient's Rights

Notice of Patient Rights and Other Information:

I understand that I may cancel this authorization at any time before the expiration date by notifying the sender of this authorization defined in Section 2. A cancellation will not change releases that happen before the cancellation.

I understand that the sender defined in Section 2 cannot prevent redisclosure of the information by the person or organization who receives my records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

I understand that I have a right to receive a copy of this authorization.

I understand that the Sender and Apple Valley Medical Center will not refuse my treatment if I choose not to sign this authorization.

I understand that my signature indicates that I have read and understand this form, and authorize release of my information as described above.

I understand that all e-mail may be sent in an unencrypted format and may not be protected from unauthorized access and interception during the e-mail transmission (only if selecting unencrypted e-mail for patient / personal requests).

Section 8: Signature

_____ _____

Patient's Signature Date (MM/DD/YYYY)

OR

_____ _____

Legal Authority / Personal Representative Signature Date (MM/DD/YYYY)

Relationship to Patient (parent, guardian, ect) _____

Internal Use:

Date Received: _____
Data Processed: _____
Staff Initials: _____