Northland Gastroenterology, P.A.

Authorization for Release of Confidential Medical Records

All sections of this authorization must be completed for the release of medical information.
The release of records may be subject to a charge.

Patient Name:_____ **Date of Birth**:_____

I hereby authorize:

_____
_____
_____
_____

To release information to:

_____
_____
_____
_____

( ) Email to:_____ ( ) Fax to:_____ ( ) Mail to address above

All records will be released unless specifically noted below

Indicate the exact information to be disclosed:

( ) Physician Notes ( ) Diagnostic Test Reports ( ) Correspondence
( ) Other (please specify): _____

Indicate extent of information to be disclosed:

( ) Include all dates of treatment ( ) Between the dates of _____ to _____ only

Indicate reason for information disclosure:

( ) Insurance ( ) Continuation of care ( ) Legal ( ) Disability ( ) Personal use
( ) Other (please specify): _____

Acknowledgement of Understanding:

- I understand that this authorization will remain in effect for 1 year from the date of signature.
- I also understand that it may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith.
- I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand by authorizing this use or discloser of information, there will be no conditions placed on my healthcare or payment for my healthcare.
- I understand that in compliance with MN Statute 144.292 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

_____ _____
Signature/mark of patient (or parent/legal guardian) **Date**

_____ _____
Witness Signature* **Date**

*If the patient is unable to sign, the person signing the authorization will be required to show proof of guardianship or other authority and relationship to patient allowing him/her to authorize the Release of Medical Information.

Return completed and signed form to:

Northland Gastroenterology, PA
1420 London Road Suite 202, Duluth, MN 55805-2422
218-724-3411 ● FAX 218-724-3408
frontdesk@northlandgastro.com