

DAKOTA PEDIATRIC CLINIC

Phone: 651-455-9697

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Inver Grove Heights, MN 55076
Fax:651-455-2012

17504 Dodd Blvd.
Lakeville, MN 55044
Fax:952-997-2592

AUTHORIZATION FOR RELEASE OF INFORMATION
TRANSFER OF MEDICAL RECORDS

Patient Name _____

Date of Birth _____

Address _____

Phone _____

This will authorize: (name of previous clinic-one clinic per form)

to release to Dakota Pediatric Clinic the following information:

- Medical Records Set (all information generated by the above facility)
- History and Physical
- Lab/X-ray Reports
- Immunization Record
- Medication Log/Current Medications
- Newborn Records

Reason for request: _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re disclosed and no longer protected by these regulations.

I understand that no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to such information will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above. I understand that I may revoke this consent at any time in written form. In any event, this consent expires within one calendar year of this date, or shall remain in effect for the period reasonably needed to complete the request for information, whichever date occurs first.

I release the above named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified. I direct that only information prior to the date of my signature be honored and that a photocopy or fax copy of this authorization be granted the same authority as the original.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.

I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and rule 164.524.

Signature of Patient/Parent or Legal Guardian

Date

Relationship to patient (if non-patient signature): _____