

**OAKDALE OBSTETRICS AND GYNECOLOGY, P.A.**

**PATIENT AUTHORIZATION AND REQUEST FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street Apartment Number

Phone Number: \_\_\_\_\_  
City State Zip

By signing this authorization, I request (please print clinic/hospital or company name)

\_\_\_\_\_, with an address and phone number of  
\_\_\_\_\_, to use

and/or disclose certain past and present protected health information (PHI) about me to:

Oakdale OB/GYN, P.A.  
3366 Oakdale Ave. No.  
Suite 450  
Robbinsdale, MN 55422  
763-587-7000  
763-587-7015 Fax

Oakdale OB/GYN, P.A.  
2855 Campus Drive  
Suite 600  
Plymouth, MN 55441  
763-587-7025  
763-559-9093 Fax

Oakdale OB/GYN, P.A.  
8559 Edinbrook Parkway  
Suite 106  
Brooklyn Park, MN 55443  
763-587-7030  
763-424-3870 Fax

Oakdale OB/GYN, P.A.  
9825 Hospital Drive  
Suite 205  
Maple Grove, MN 55369  
763-587-7050  
763-420-7948 Fax

Specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released:

\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on: \_\_\_\_\_  
{Expiration date or defined events}

I do not have to sign this authorization in order to receive treatment from Oakdale Obstetrics and Gynecology, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 8559 Edinbrook Parkway, Suite 106, Brooklyn Park, MN 55443.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient (If signed by Guardian)

\_\_\_\_\_  
Patient's Previous Last Name

\_\_\_\_\_  
Print Legal Guardian Name, if Applicable

\_\_\_\_\_  
Date

*PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION*