Oakdale Obstetrics & Gynecology

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

5700 Bottineau Blvd Suite 210 Crystal, MN 55429

Phone: 763-587-7000 | Fax: 763-587-7015 | comments@oakdaleobgyn.com

Patient Name_____ Previous Name _____

Date of Birth _____/_____/_____ Home # _____ Cell # _____

****Please fill out this form completely. All incomplete forms will be returned for completion. ****

____ This will authorize Oakdale OB/GYN to **request** information **FROM** (please do not send CD records):

____ This will authorize Oakdale OB/GYN **release** records **TO**:

Name/Organization _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Please Choose from the following information to be released:(Please circle items needed)

All Gyn Records	Radiology Reports	Laboratory Reports	Mammogram Reports
All OB Records	Pap Smears/Pathology	Operative Reports	History and Physical
Progress Notes			

For the following date(s) of treatment or condition: _____

*Records included will be for the last 24 months unless otherwise specified.

***Oakdale OB/GYN will not release records from other providers**

I am requesting the information for use by: (please circle)

Continuing Care **(no charge records going to another clinic)** Transfer Care **(no charge records going to another clinic)**

Personal Use **(charge of $ 1.35 per page plus tax)**

Reason for Transfer:
Moving Insurance Change Dissatisfaction Other

Legal **(retrieval fee $17.96 plus $1.34 per page plus tax)**

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ Mental Health ☐ HIV/STDs ☐ Pregnancy ☐ Research Study Information

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of the healthcare is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time in writing to the clinic. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by the confidentiality laws.

This authorization will expire 90-days from the date signed below unless another date or event is entered here_____

Signature of Patient/Legal Representative

_____	_____	_____
Date	Signature of Patient/Legal Representative	Relationship to the Patient

Signature of Minor Patient Required for the Following Records

Minor: A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

_____	_____
Date	Signature of Minor Patient