Life Medical, P.A.

4201 Excelsior Blvd
St. Louis Park, MN 55416
Telephone: 952-933-8900
Fax: 952-945-9536

AUTHORIZATION FOR
RELEASE OF
INFORMATION

Patient's Name: _____DOB:_____

Address: _____

City: _____ State: _____ Zip: _____

This will authorize _____ Fax#_____

To release information to_____

Information to be released includes records from the following dates: _____

Information to be released:

- ☐ Cardiac Tests
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Emergency Department Examination
- ☐ History & Physical Examination
- ☐ Laboratory Reports: _____
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Physician Orders
- ☐ Physician Progress Notes
- ☐ Radiology Films
- ☐ Other (specify) _____
- ☐ All records for the last year.

Reports related may include information regarding mental status/drug/alcohol and HIV testing results. If there is specific information that you do not want released, please write it here: _____

_____

_____

This information is needed for the following purpose(s): _____

This authorization will expire upon the earliest of the following dates: 1) twelve months following date of signature on this form, 2) the date the stated purpose is fulfilled, 3) the date that I revoke this authorization, I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to extent that Life Medical, P.A. has relayed on the authorization. A photocopy or facsimile of this authorization shall be treated as valid as the original. I understand that Life Medical, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

_____ Date: _____

Signature of Patient or Patient Representative Must be filled in

(after completing form, please print, sign, date and fax to Life Medical at: 952-945-9536)

(If Patient's representative, under what legal authority are you signing?)

○ Parent ○ Conservator ○ Guardian ○ Health Care Agent

○ Other (specify) _____