

AUTHORIZATION TO REQUEST PATIENT INFORMATION

Patient Information	NAME: _____ DATE OF BIRTH: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider – (<i>Who</i> has the information you want released?)	Clinic: _____ Physician: _____ Fax: _____
Receiving Party (<i>Where</i> do you want the information sent? <i>Who</i> may have the information?)	Name/Clinic Name: <u>Children's Respiratory & Critical Care Specialists, P.A.</u> Address: <u>2530 Chicago Ave S, Suite #400</u> Phone: <u>(612) 813-3300</u> Fax: <u>(612) 813-3349</u> City: <u>Minneapolis</u> State: <u>MN</u> Zip: <u>55404</u>
Information to be Released (<i>What</i> do you want sent or released? Check all boxes that apply.)	Routine Record Sets: <input type="checkbox"/> Clinic (office visit, lab, radiology – CXRs (actual CD/film please), medicines, immunizations) <input type="checkbox"/> Billing Records <input type="checkbox"/> Any and all records (includes ALL types of records listed below) Only record types checked below: <input type="checkbox"/> Operative Reports <input type="checkbox"/> Correspondence <input type="checkbox"/> Hospital Visits/Summaries <input type="checkbox"/> Special Diagnostic Reports <input type="checkbox"/> Home Care orders <input type="checkbox"/> Pulmonary Function Tests Optional limits – Disclose only records related to the following: Date(s) of service: _____ injury or illness: _____
Release Instructions (<i>How</i> and <i>When</i> do you want the information?)	Date information is needed: _____ Release Method (check one): <input type="checkbox"/> Paper/Mail <input checked="" type="checkbox"/> Fax – Please list fax number(s): <u>(612) 813-3349</u>
Purpose of release (<i>Why</i> is it needed?)	<input type="checkbox"/> Continuing care <input type="checkbox"/> Litigation/legal <input type="checkbox"/> Transfer of care <input type="checkbox"/> Social security appeal <input type="checkbox"/> Insurance application <input type="checkbox"/> Social security disability determination <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Personal use or review

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Children's Respiratory & Critical Care Specialists, P.A. ("CRCCS") Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- CRCCS will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- CRCCS records may include records that it received from other organizations. If these records have been used by CRCCS and filed in the record CRCCS maintains about you, these records may be released with your CRCCS records.
- CRCCS cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release CRCCS from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above

Signature _____

Date _____

Click to Submit

**NOTE: By submitting this document to Children's Respiratory & Critical Care Specialists, you are providing implied consent that you understand the risks of sending personal health information in a non-secure email format.*