

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**  
*(ALL SECTIONS OF THIS RELEASE MUST BE COMPLETED OR THE RELEASE MAY NOT BE PROCESSED)*

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_

MAIDEN OR OTHER NAME (S) \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Records Needed by:  I have an appointment on \_\_\_\_\_  I will pick-up on \_\_\_\_\_

**Patient/Patient Representative requests only:**

- Check this box if you do not want your records sent via electronic means (e.g. NextMD or on a CD/DVD).  
 Check this box if you are requesting your entire medical record

**I authorize Minnesota Gastroenterology, P.A. to use or disclose (as applicable) the following information (check all that apply):**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Provider Notes              | <input type="checkbox"/> Lab(s) Reports    | <input type="checkbox"/> HIV Results/Testing | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Hospital Records    | <input type="checkbox"/> Research Records  |
| <input type="checkbox"/> Infusion Records            | <input type="checkbox"/> Billing Statement | <input type="checkbox"/> Procedure Images    | <input type="checkbox"/> Special Tests     |
| <input type="checkbox"/> Other (specify) _____       |  |  |  |

Please indicate date(s) of treatment: \_\_\_\_\_

Health facility, doctor, person(s)  
RELEASING Protected Health Information:

Minnesota Gastroenterology, P.A.  
Attention: HIM  
P. O. Box 14909  
Minneapolis, MN 55414  
612-870-5525 (fax)/612-871-1145 opt 2 (phone)

The information described above may be  
DISCLOSED/RELEASED to the following recipients:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address – or fax number

\_\_\_\_\_  
City, State Zip

**Reason for the use or disclosure (as applicable) is for the purpose of:**

- Continuing Medical Care  Insurance  Legal  SSI Disability Appeal  
 Research  At the Request of the Patient  Other Specify \_\_\_\_\_

◆ I understand that Minnesota Gastroenterology, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

- ❖ If the medical information to be disclosed will result from treatment for research purposes, Minnesota Gastroenterology, P.A. will not provide the treatment if I am unwilling to sign this authorization form.
- ❖ If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Minnesota Gastroenterology, P.A. will not provide the treatment if I am unwilling to sign this authorization form.

◆ I understand that I may revoke this authorization by sending a written request for revocation to Minnesota Gastroenterology, P.A.'s Privacy Officer. If I revoke this authorization, Minnesota Gastroenterology, P.A. will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Minnesota Gastroenterology, P.A. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

◆ I understand that there may be a fee associated with the release of my medical information.

◆ I understand that this authorization will expire 12 months from the date signed unless I indicate otherwise here \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date (DD/MM/YYYY)

\_\_\_\_\_  
Relationship to Patient (e.g. Self, POA)

Reason Patient is Unable to Sign Release:  Minor  Deceased  Other: \_\_\_\_\_  
(Please specify and provide legal paper as needed)