All About Children Pediatrics, P.A.
Phone: 952-943-8200
Fax: 952-943-8206
www.allaboutchildren.net

Medical Records Release Authorization

Patient Name_____ SS#_____
(Full legal name)

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address:_____

A) **I hereby Authorize records <u>FROM</u>:**
(physician/practice releasing/sending information)

Practice/Doctor Name: **All About Children Pediatrics, P.A.**

Address: **12200 Middleset Road, Suite 100**

City/State/Zip: **Eden Prairie, Minnesota, 55344**

Phone# **(952) 943-8200** Fax# **(952) 943-8206**

B) To send information <u>TO:</u>
(physician/practice or person receiving the information)

Name:_____

Address:_____

City/State/Zip:_____

Phone#_____ Fax#_____

<u>For the Purpose of</u> *(check all that apply)***:**

- ☐ Switching clinics
- ☐ Moving out of state or country
- ☐ Specialist/Consultation
- ☐ Insurance related
- ☐ Legal request
- ☐ Personal Use
- ☐ Other (specify)_____

<u>Date Range:</u>

_____**to** _____

<u>Copy Form:</u>

- ☐ Copy on CD (*one time)*
- ☐ Printed Copy (*see *Fees*)
- ☐ Fax to: _____

<u>Initial to indicate the information to release:</u>

- ☐ Entire Chart (any/all medical records)
- ☐ Health Summary Only
- ☐ Immunization Records
- ☐ Lab/Pathology Reports
- ☐ Radiology/X-Ray/MRI Reports
- ☐ Specialist Reports _____
- ☐ Other (be specific) _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

_____ _____***Subject to Fees**
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

***Fee Information:** *For continuity of care, All About Children Pediatrics will electronically transfer a reasonable portion of your medical records directly to a physician and/or medical practice as a courtesy. If requesting entire chart records, All About Children will provide and/or send one copy on CD as a courtesy. In the case of printed copy requests, we reserve the right to charge the fee schedule as set by the State of Minnesota Statue 144.292. A $17.79 handling fee, $1.34 cents per page and postage will be invoiced to you. By signing this authorization, you are agreeing to pay All About Children Pediatrics for any printed copies and/or additional CD's of your records.*

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