721 Snelling Avenue South
St. Paul, MN 55116
651-690-1311

Patient Authorization Form

Name and address of where you are requesting records from:

_____
_____
_____

Name and address of where you are sending your records to:

_____
_____
_____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be used or disclosed:

_____
_____

This information is being requested for the following purpose(s):

_____
_____

This authorization shall remain in effect from the date signed below until _____ (Expiration date or event).

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address below, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPPA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (Except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

[ ] If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Patient Date Of Birth: _____
Signature: _____ Today's Date: _____
Relationship to Patient (If signed by personal representative of Patient): _____

Parkway Family Physicians
Attention Privacy Officer
721 Snelling Avenue South
St. Paul, MN 55116