PATIENT REQUEST FOR ACCESS TO PATIENT HEALTH INFORMATION

Patient Name (last, first, middle initial) ______ Social Security # ______

Street Address ______ City ______ State ______ Zip ______

Date of Birth ______ Day Phone # ______ Evening Phone # ______

INFORMATION RELEASED FROM	INFORMATION RELEASED TO/EXCHANGED WITH
Facility name and address	Name
Street Address	
City, State, Zip	

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

____

____

Visit Date ______ 0 View Record 0 Receive Copy

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

0 History and Physical
0 Consultation(s)
0 Allergy Test Results
-OR-
0 Any and all medical records

0 Laboratory Results
0 Billing Records/Statements (date)
0 Other______

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH AND/OR HIV/HIV-RELATED ILLNESSES WILL BE RELEASED UNLESS INDICATED HERE:

0 **DO NOT RELEASE RECORDS RELATED TO MENTAL HEALTH AND/OR HIV**

THIS INFORMATION IS TO BE USED FOR THE PURPOSE OF:

0 Patient Access 0 Insurance Application 0 Social Security Disability Determination/Appeal

0 Litigation 0 Continuing Care 0 Insurance Payment

Other (specify):______

Authorization expiration date or event: ______(if left blank, will expire one year from date of signature)

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the informatic released prior to notification of revocation. Eisenstadt Allergy & Asthma, LLP will not refuse or restrict my treatment if I choose not to sign this authoriza tion. A photocopy/fax of this authorization will be treated in the same manner as an original.

Further, I realize that Eisenstadt Allergy & Asthma cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Eisenstadt Allergy & Asthma is released from any and all liability resulting from redisclosure. I have read and understand my rights.

______ Patient/Legal Representative Signature ______ Date

______ Authority to act on behalf of Patient (attach document)

Information released by:______ Date:______