

Emily S. Birkholz, M.D.
 Nathan D. Carpenter, M.D.
 Seth A. Consoer, M.D.
 Justin J. Kuiper, M.D.



1630 Adams Street
 Mankato, MN 56001
 Phone: 507-345-6151
 Fax: 507-625-1096
 www.mankatoeyedoctors.com

Authorization to Release Protected Health Information

Patient Information	Name:		Date of Birth:
	Address:		Phone:
	City:	State:	Zip:
	Previous Name:		
Health Care Facility/ Provider	Who has the information you want released?		
	Name:		Location:
	Address:		Fax #:
	City:	State:	Zip:
Requestor	Where should the information be released?		
	Name:		Location:
	Address:		Fax #:
	City:	State:	Zip:
Information to be Released/ Disclosed	Release Records Concerning: _____ Specific diagnosis or treatment or specific dates of service		
	<input type="checkbox"/> Entire Patient Record <input type="checkbox"/> Office Notes/Procedures <input type="checkbox"/> Lab Results/Pathology Reports <input type="checkbox"/> Record of mental health or substance abuse treatment <input type="checkbox"/> Record of HIV and communicable disease testing	<input type="checkbox"/> Financial/Billing <input type="checkbox"/> Hospital notes <input type="checkbox"/> X-Rays <input type="checkbox"/> Nursing home, home health, hospice and other physician records <input type="checkbox"/> Other: _____	
Reason for Release/ Disclosure	<input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Personal	<input type="checkbox"/> Continuation of Medical Care <input type="checkbox"/> Transferring Care <input type="checkbox"/> Other: _____	
	Revocation I understand that this authorization will be in effect for 12 months from the date signed unless I specify an earlier termination. I must submit a new authorization form after the expiration date to continue the authorization. Please list an earlier expiration date, if earlier than 12 months: _____		
Authorization & Signature	I understand that I have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. The practice places no condition to sign this authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.		
	Signature of Patient or Authorized Representative: _____ Date: _____		

*You have the right to receive a copy of signed authorizations upon request.

*Authorized representative may be required to submit copies of legal documents supporting their authority to act on a patient's behalf.