

JOHNSON STREET MEDICAL CLINIC

Authorization for release of Medical Records

To From

To From

JOHNSON STREET MEDICAL CLINIC

2904 Johnson Street

Minneapolis, MN 55418

(612) 782-0900 Phone

(612) 788-4930 Fax

Reason for Transfer:

_____ Change of clinic

_____ Insurance change

_____ Continuing care

_____ Personal

_____ Other (please explain) _____

Please transfer the following information:

_____ All records (if all records are not required, please check the information requested)

_____ X-Ray reports

_____ Hospital admissions

_____ X-Ray films

_____ EKG reports

_____ Immunization records

_____ Laboratory reports

_____ Physical examination

_____ Pathology reports

_____ All information from _____ to _____

Expiration Date of Authorization

This authorization is effective through ____ / ____ / ____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to JOHNSON STREET MEDICAL CLINIC. You should contact the Medical Records department to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print or Type)

D.O.B.

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient