ENDOCRINOLOGY
Clinic of Minneapolis

Internal Use Only | Account #_____
Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:	
	DOB: / /	PREVIOUS NAME(S):
2. RELEASE MY RECORDS FROM	FACILITY NAME:	PHONE:
	DR. NAME:	FAX:
3. SEND MY RECORDS TO	NAME:	ATTN TO:
	ADDRESS:	
	CITY:	STATE: ZIP:
	PHONE:	FAX (For Continuing Care ONLY):
	Email: (Only if you want records sent via encrypted email)	
4. TYPES OF RECORDS	BODY PART:	
	DATE(S) OF SERVICE:	
	☐ Diagnostic Tests ☐ Lab Reports ☐ Radiology Reports ☐ Office Notes ☐ Other_____	
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____	
	"Verbal disclosure" authorizes Endocrinology Clinic of Minneapolis to discuss my care with the person(s) indicated in this section:	
6. REASON FOR REQUEST	☐ Personal Use ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care	
7. RETURN COMPLETED FORMS TO:	**MAIL TO OR DROP OFF:** Endocrinology Clinic of Minneapolis 7701 York Ave S #180 Edina, MN 55435	**FAX TO:** 952-456-7291
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.	
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicted above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign this form, unless specified: _____ • If I provided an email address is section 3, I understand that the requested records will be sent via encrypted email, or it may be sent to a patient portal SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.	

Electronic or Typed Signatures cannot be accepted