SCHWIETERS MEDICAL, PLLC
2781 PILOT KNOB ROAD
EAGAN, MN 55121
PHONE: (651) 289-7300
FAX: (651) 289-7301

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **BIRTHDATE:** _____/_____/_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIPCODE:**_____

PHONE (HOME): _____ **WORK:** _____ **CELL:** _____

THIS WILL AUTHORIZE OUR PROVIDER TO (CHOOSE ONE): ☐ **RELEASE TO** ☐ **REQUEST FROM** ☐ **EXCHANGE WITH**

NAME/ORGANIZATION (REQUIRED): _____

ADDRESS (REQUIRED): _____

CITY (REQUIRED): _____ **STATE:** _____ **ZIPCODE:** _____

PHONE (REQUIRED): _____ **FAX:** _____

THE FOLLOWING INFORMATION IS TO BE RELEASED (CHECK APPROPRIATE BOX OR CHECK ALL RECORDS)

☐ **HOSPITAL SUMMARIES** ☐ **MEDICATION HISTORY** ☐ **PROGRESS NOTES**

☐ **ALL RECORDS (TO INCLUDE PSYCHIATRIC, MENTAL HEALTH, AND CHEMICAL DEPENDENCY)**

☐ **ALL DATES** ☐ **SPECIFIC DATES:** _____ **TO** _____

I AM REQUESTING THIS INFORMATION BE RELEASED FOR THE FOLLOWING PURPOSE(S):

☐ **CONTINUITY/COORDINATION OF CARE WITH ANOTHER PROVIDER** ☐ **ATTORNEY REVIEW**

☐ **INSURANCE CLAIM/APPLICATION** ☐ **OTHER**

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME TO THE ADDRESS LISTED AT THE TOP OF THIS FORM. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT TREATMENT MAY NOT BE CONDITIONED ON MY AGREEMENT TO SIGN THIS AUTHORIZATION.

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT ONCE INFORMATION IS RELEASED PURSUANT TO THIS AUTHORIZATION WE CANNOT PREVENT THE REDISCLOSURE TO ANOTHER THIRD PARTY.

A COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL

_____ **DATE:**_____
SIGNATURE OF PATIENT/AUTHORIZED PERSON

_____ **DATE:**_____
SIGNATURE OF AUTHORIZED PERSON

REASON PATIENT IS UNABLE TO SIGN: ☐ **MINOR** ☐ **DECEASED** ☐ **OTHER**