MINNESOTA PERSONALIZED MEDICINE

AUTHORIZATION TO RELEASE & DISCLOSE PATIENT INFORMATION

Patient Information	Name: _____Date of birth: _____ Address: _____Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Practitioner	Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
Receiving Clinic	Name: Minnesota Personalized Medicine Address: 1409 Willow Street, Suite 501, Minneapolis, MN 55403 Phone: 612-345-5029 eFax: 1-612-392-3957 (Please dial "1" even from 612 area code)
Information to be Released	_X_Record from date(s) of service: ____2018-Present_____ __Other:
Release Instructions	Date information is needed: ___ASAP_____ Release Method/Format requested: (select one) _X_Fax __ Other:
Purpose of Release	_X_ Continuing care __ Other:

- Minnesota Personalized Medicine is firmly committed to protection of your health information and will not release any of your health information to anyone or any organization without your explicit consent.
- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Please contact us if you choose to revoke your authorization.
- Minnesota Personalized Medicine will not restrict your treatment if you choose not to sign this authorization.
- A photocopy or fax of this authorization will be treated in the same way as an original.
- Minnesota Personalized Medicine records may include records that it received from other organizations. If these records have been used by Minnesota Personalized Medicine and file in the record Minnesota Personalized medicine maintains about you, these records may be release with your Minnesota Personalized Medicine records.
- Minnesota Personalized Medicine cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization you release Minnesota Personalized Medicine from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian Signature Date Authority to act on behalf of patient (Attach document)