Richfield Medical Group
6440 Nicollet Ave. So.
Richfield, MN 55423
Phone: 612-861-1622
Fax: 612-861-2307

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name:_____DOB:_____

Social Security#:_____Phone:_____

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:** **Address must be provided for record release**
_____	_____
_____	_____
_____	_____

Please list Clinic (Organization) Name, Address, City, State, and Zip Code

INFORMATION TO BE RELEASED (IF OVER 25 PAGES, PLEASE MAIL)

_____ All Medical Records* **____ Other(specify)_____**

____ Lab Reports **_____ Xray Reports**

***Excludes all records pertaining to Psychiatric/Mental Health, Chemical Dependency and or HIV/HIV Related Illnesses. These Records Will Not Be Released unless you Specifically Authorize the Richfield Medical Group to Release Them. I authorize the release of Psychiatric/Mental Health, Chemical Dependency and or HIV/HIV Related Illnesses records. If in agreement please initial._____ Date_____**

This information is being released for the purpose of:
___ Continuing Care **___ Changing Clinics**
___ Other_____

This consent will automatically expire 12 months from the date of my signature. I have been notified that I can revoke this request in writing. Please see our Notice of Privacy Practices on how to revoke authorization. The Richfield Medical Group is not responsible for any information released prior to revocation in writing.

Further the Richfield Medical Group cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to Privacy rule protections. Therefore the Richfield Medical Group is released from any and all liability resulting from redisclosure. I understand that a photocopy of this release will serve as an original.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits except as permitted by law.

Signature_____Date_____