Authorization to Release Medical Records

By filling out this form, I, _____, being the patient, parent, or legal guardian of the patient, do hereby request that the listed provider or clinic release medical records as specified by the form below.

CLINIC OR PROVIDER TO RELEASE RECORDS TO GROW PEDIATRICS:		
Clinic or Physician Name:		
Address:	Phone:	
City:	State:	Zip Code:

MEDICAL RECORDS TO BE TRANSFERRED:

Type of Release:
_____ Entire Patient Record
_____ All records relating to _____(please specify)
_____ Other:

Reason for Release:
___ Change of Insurance
___ Consult/Second Opinion
___ Moving Out of Town
__ Change of Physician
___ Other:

If transferring to Grow Pediatrics,
please let us know how you heard about us:

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re disclosed and no longer protected by these regulations.
I understand that no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to such information will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above. I understand that I may revoke this consent at any time in written form. In any event, this consent expires within one calendar year of this date, or shall remain in effect for the period reasonably needed to complete the request for information, whichever date occurs first. I release the above named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified. I direct that only information prior to the date of my signature be honored and that a photocopy or fax copy of this authorization be granted the same authority as the original. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law. I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and rule 164.524.

Patient, Parent, or Legal Guardian Signature:	Date:
Address:	Phone:

Records should be mailed to: **5975 Carmen Ave, IGH, MN 55076**; or faxed to **855-281-2245**.