

# METROPOLITAN OBSTETRICS & GYNECOLOGY, P.A.

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

I AUTHORIZE RELEASE OF RECORDS  TO  FROM

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I AUTHORIZE RELEASE OF RECORDS  TO  FROM

METROPOLITAN OBSTETRICS & GYNECOLOGY, P.A.

Gallery Professional Bldg  
17 W. Exchange St. #622  
St. Paul, MN 55102  
Ph. 651-227-9141  
Fax 651-291-5992

Woodbury Medical Arts Bldg  
2101 Woodwinds Dr. #300  
Woodbury, MN 55125  
Ph. 651-265-6745  
Fax 651-714-8255

Maplewood Professional Bldg  
1655 Beam Ave. #102  
Maplewood, MN 55109  
Ph. 651-770-1385  
Fax 651-770-0672

### INFORMATION TO BE RELEASED

- |   |                         |
|---|-------------------------|
| <input type="checkbox"/> PROGRESS NOTES           | Approximate dates _____ |
| <input type="checkbox"/> LAB RESULTS              | Approximate dates _____ |
| <input type="checkbox"/> OPERATIVE REPORTS        | Approximate dates _____ |
| <input type="checkbox"/> X-RAY/ RADIOLOGY REPORTS | Approximate dates _____ |
| <input type="checkbox"/> OTHER                    | Approximate dates _____ |
| <input type="checkbox"/> ALL                      |                         |

### PURPOSE OF DISCLOSURE

- Continuing Care  Other \_\_\_\_\_

- Please indicate any restrictions. (Specify): \_\_\_\_\_
- I understand I may revoke this authorization at anytime by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- This authorization will automatically expire one year from the date of my signature, or \_\_\_\_\_ (period of time, for example 2 days, or 3 weeks or 5 months) from the date of my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Metropolitan Obstetrics & Gynecology cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.

\_\_\_\_\_  
SIGNATURE OF PATIENT / AUTHORIZED PERSON

\_\_\_\_\_  
AUTHORIZED PERSON'S AUTHORITY TO SIGN  
(PARENT, GUARDIAN, POWER OF ATTORNEY, ETC.)

\_\_\_\_\_  
DATE

REASON PATIENT IS UNABLE TO SIGN:  MINOR  DECEASED  OTHER: \_\_\_\_\_

