mncome™
MINNESOTA CENTER FOR OBESITY, METABOLISM AND ENDOCRINOLOGY PA

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	NAME: DATE OF BIRTH: ADDRESS: DAY PHONE: CITY: STATE: ZIP:
FORWARDING CLINIC/PROVIDER/ HOSPITAL **SENDING** THE INFORMATION	PROVIDER NAME: CLINIC NAME: FAX: ADDRESS: PHONE: CITY: STATE: ZIP:
RECEIVING PARTY **WHERE** INFORMATION GOES	PROVIDER NAME: ATTN: CLINIC NAME: FAX: ADDRESS: PHONE: CITY: STATE: ZIP:
INFORMATION TO BE RELEASED **WHAT** DO YOU WANT SENT OR RELEASED?	☐ OFFICE VISITS DATES: ☐ BILLING RECORDS DATES: ☐ ANY AND ALL RECORDS (INCLUDES ALL RECORDS LISTED BELOW) ☐DISCHARGE SUMMARY ☐RADIOLOGY REPORTS ☐EMERGENCY RECORDS ☐MEDICATION RECORDS ☐HISTORY & PHYSICAL EXAM ☐REHAB RECORDS (PT/OT/ST) ☐IMMUNIZATION/ALLERGY RECORD ☐CHEMICAL DEPENDENCY/SUBSTANCE ABUSE ☐OPERATIVE REPORT ☐LABORATORY REPORTS ☐PATHOLOGY REPORTS ☐PATHOLOGY SLIDES/BLOCKS ☐CONSULTATIONS ☐PROGRESS NOTES/CLINIC NOTES ☐MENTAL HEALTH RECORDS ☐OTHER (SPECIFY) OPTIONAL LIMITS: RECORDS RELATED ONLY TO FOLLOWING: DATE(S) OF SERVICE: INJURY OR ILLNESS:
RELEASE INSTRUCTIONS **WHEN** DO YOU WANT THE INFORMATION?	DATE INFORMATION IS NEEDED: (NOTE: PLEASE ALLOW 7 – 10 DAYS FOR PROCESSING)
PURPOSE OF RELEASE **WHY** IS IT NEEDED?	☐CONTINUING CARE ☐TRANSFER OF CARE ☐ SOCIAL SECURITY APPEAL ☐INSURANCE APPLICATION * ☐PERSONAL USE* ☐SOCIAL SECURITY DISABILITY DETERMINATION* ☐INSURANCE PAYMENT/CLAIM ☐LITIGATION/LEGAL* ☐OTHER*: A **$20.00** FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.292 AND FEDERAL RULE 45 C.F.R. §164.524

*This authorization lasts for one year after the date you sign it unless you enter a different date or expiration date here:_____
*This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
*MNCOME will not restrict my treatment if I choose not to sign this authorization
*A photocopy/fax of this authorization will be treated in the same way as an original
*MNCOME's records may include records that it received from other organizations. If these records have been used by MNCOME and filed in the record MNCOME maintains about you, these records may be released with your MNCOME records
*MNCOME 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 general privacy protections after it is released. By signing this authorization, you release MNCOME 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.

_____	_____	_____
PATIENT/LEGAL GUARDIAN SIGNATURE	DATE	AUTHORITY TO ACT ON BEHALF OF PATIENT (ATTACH DOCUMENT)