Entira FAMILY CLINICS
Where generations thrive®

Entira Family Clinics
Medical Records Department
2025 Sloan Place, Suite 35
St Paul, MN 55117
Phone: 651-788-4446
Please fax all records to Fax: 651-771-0083

Patient Authorization for Release of Protected Health Information

Patient Information:

_____ Patient Name / Previous Name

_____ Date of Birth

_____ Street Address

_____ Daytime Phone

_____ City, State, ZIP

I Hereby Authorize Entira Family Clinics to: ☐ **Release Information to** **(OR)** ☐ **Obtain Information From**

_____ Name of Person, Institution, Agency, Clinic, Facility, Company or Firm

_____ Street Address

_____ Phone Number

_____ City, State, ZIP

_____ Fax Number

Reason for request ☐ specialist ☐ move ☐ seasonal move ☐ primary clinic request ☐ work comp ☐ insurance ☐ dissatisfied ☐ legal
☐ transfer of care (specify reason): _____
☐ other: _____

IMPORTANT - Indicate only the information that you are authorizing to be released. This consent to release information is limited to the following and includes the most recent 24 months of information unless specified.

☐ **Specific dates, years of treatment or services:** _____
☐ **All Health Information** *(includes records relating to HIV, pregnancy, mental health, alcohol, drug treatment ,and records relating to communicable diseases)*

Or specify:

☐ **Clinic Visit Notes / Care Plan**
☐ **Consultation / Follow-up Reports**
☐ **Lab Report / Pathology Report / EKG's**
☐ **X-Ray Report / Radiology Report**
☐ **Immunization Record**
☐ **Health Care Directive**
☐ **Hospital / ER Reports (Admit and Discharge)**
☐ **Occupational Health / Workers Comp**
☐ **Other (specify):** _____

I understand that by signing this form, I am requesting the above health information be sent to or requested from the third party named above. I may stop this consent at any time in writing except to the extent that the information has already been released and my request to stop will not work for that health information. I understand that when the health information is disclosed, the clinic has no control over the information, and it could be re-disclosed by the third party. I understand that if the information is being released to a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization to whom my information is released is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. In addition, I hereby release the clinic from any and all liability arising directly or indirectly from disclosure authorized by this consent.

This consent expires one year from my signature date or as of the following date or event: _____

Patient's Signature _____ Date _____

Or legally authorized representative's signature _____ Date _____

Representative's relationship to patient (parent, guardian, etc.) _____