AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Release to:

Dr. Kim Lane
Wellness Lane, LLC
7810 Gloria Circle
Mounds View, MN 55112
o- 651-348-8089
f-651-203-7399

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Release From:

_____

Name of Health Care Provider/Physician/Facility/Medicare Contractor

_____

Street Address City

Phone: Fax:

_____

State and Zip Code

RE: Patient Name: _____Date of Birth:_____
Address:_____
_____Phone:_____

Health information to be released:
Dates of service _____ to _____

O History and Physical	O Progress/Clinic notes	O Radiology reports
O Laboratory reports	O Discharge summary	O Radiology images
O Emergency reports	O Photographs	O Visit reports
O Surgery reports	O Care plan	O Cardiac/Ecg reports
O Medications	O Immunizations	O Immunization lot numbers and brands

O Other:_____

All information will be released unless you tell us not to release the following by initialing below:

_____Do **NOT** release Alcohol/Drug Use or Abuse records
_____Do **NOT** release Mental Health records
_____Do **NOT** release HIV/AIDS records.

Type of communication:
☐ Hard copies (Paper) ☐ CD(requires PDF viewing capabilities) ☐ Verbal ☐ Review of records
Delivery by:☐ Mail ☐ Fax ☐ Patient will pick up

Purpose of release:
☐Personal ☐ Continued Care appointment date_____ ☐ Other:_____
There may be a charge/fee for copies of records.

Authorization/Revocation:

This authorization will terminate in one year unless otherwise specified_____;
I understand that I may stop the release at any time by submitting a written request to stop or cancel release of records.
I understand that once records have been released to another facility there is no way to cancel or stop this release.
I understand that when the health information is released the information could be re-disclosed by a third party that receives it and may no longer be protected by the federal or state privacy laws.
I understand that treatment, payment or other benefits are not a condition of signing this form.
I understand that I must sign this form to have my records released.

_____ _____

Signature Date

_____

Relationship if signing for minor child

A photocopy of this authorization is as valid as the original.