AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Release from:

Dr. Kim Lane
Wellness Lane, LLC
7810 Gloria Circle
Mounds View, MN 55112
o- 651-347-1952

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Release to: ____

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 Summary Health O Remedy Summary List

Type of communication:
☐ Hard copies (Paper)
Delivery by: ☐ Mail ☐ Patient will pick up/hand deliver

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.