Receiving information

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Information:

____ ______________________
Patient Name (Last, First, Middle Initial) Date of Birth

____ ______________________
Street Address City/State/Zip

________________ ________________
Home phone number Daytime phone number

Release Records To:

Pediatric Surgical Associates, Ltd.
Name/Provider/Clinic

2530 Chicago Ave. South Suite 550
Street Address

Minneapolis, MN 55404
City/State/Zip

Release Records From:

____
Name/Provider/Clinic

____
Street Address

____
City/State/Zip

____________ ____________
Phone number Fax number

Information to be Disclosed

The information covered by this authorization includes: ____

Purpose for Release:

☐ Further Medical Treatment ☐ Change of Clinic ☐ Legal/Attorney Request

☐ Other: ______________________________________

Expiration Date of Authorization

This authorization will remain in effect for one year from the date of my signature. You may revoke or terminate this authorization by submitting a written revocation to Pediatric Surgical Associates, Ltd. **You should contact the compliance officer to terminate this authorization.**

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

__________________________________ ________________ ____________
Signature of Patient/Parent or Guardian of Patient Relationship to Patient Date

Please mail or fax records to:

Pediatric Surgical Associates
2530 Chicago Ave. South, Ste. 550
Minneapolis, MN 55426

Phone: (612) 813-8000
Fax: (612) 813-8005