



Pediatric Surgical Associates, Ltd.

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

Phone: (612) 813-8000

2530 Chicago Ave. South, Ste. 550

Fax: 952-835-9443

Minneapolis, MN 55426