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
2530 Chicago Ave. South, Ste. 550
Minneapolis, MN 55426

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