APPLE VALLEY MEDICAL CLINIC, LTD.

14655 Galaxie Ave., Apple Valley, MN 55124 • Phone: 952.432.6161 • Fax: 952.432.7019
Release of Information: Monday through Friday • Hours: 8am to 4:30pm • Phone: 952.432.6161 x 4248

www.applevalleymedicalcenter.com at APPLE VALLEY MEDICAL CENTER

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ SSN# _____ Phone: _____ Medical Record # _____
Health Information Released **FROM:** ☐ Apple Valley Medical Clinic ☐ Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____	Health Information Released **TO:** Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____
Health Information to be **RELEASED:**	Date(s) of Treatment Received: _____ (If dates not specified, only the most recent year will be released) ☐ Clinic Visits ☐ Radiology Reports ☐ Labs ☐ Radiology Images ☐ Immunization ☐ Other? _____ **All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:** ____ Do Not Release Chemical Dependency Treatment records ____ Do Not Release Mental Health records ____ Do Not Release HIV/AIDS records _____ **By initialing here I give consent for Apple Valley Medical Clinic to verbally communicate with the listed authorized recipient.**
Purpose of Release:	• Personal • Attorney • **Continued Care - Appt Date:** _____ • Insurance • Disability/Social Security • Other: _____ • Transfer from Practice/Reason? _____ **There may be a charge/fee for copies of records**
Delivery Method:	• **Mail** • **Fax** • **Pick up by patient/authorized designee (requires valid photo ID)**
Authorization/ Revocation	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to the Apple Valley Medical Clinic's Health Information Management department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be redisclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Apple Valley Medical Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X_____ X_____ **Signature** (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) **Date** _____ Relationship to patient (if not patient) **NOTE:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. *A photocopy of this authorization is as valid as the original.*
Staff Use Only:	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____