Authorization for Release of Information

By completing this form you are authorizing Pipe Trades Family Health and Wellness Center to request information from the provider below for the exclusive purpose of treating the named patient listed below.

Patient name	Previous last name (if any)	Date of birth	Phone #
Street address	City	State	Zip code

From: Provider/facility

Provider name	Facility name	Phone #	
Street address	City	State	Zip code

Send to:
Pipe Trades Family Health and Wellness Center
13998 Maple Knoll Way
Maple Grove, MN 55369
Fax: 651.348.8853

Records requested: ☐ All *or* ☐ Between ____ /____ /_____ - ____ /____ /_____	
___Clinic visit notes	___Lab reports
___Mental health records	___Pathology reports
___Radiology reports	___Other (specify)_____MRI results_____

This authorization will automatically expire in 12 months or _____. I understand that this authorization expends to all of any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alchohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of informaiton as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):
___HIV/AIDS ___Mental Health ___Drug and/or Alcohol Abuse ___Genetic Counseling/Testing Information

I understand that this authorization is revocable upon written notice to the office where the orginal authorization is retained, except to the extent that action has already been taken on this authorization. I further understand I need not sign this form in order to assure treatment or payment. I understand that upon reciept, Pipe Trades Family Health and Wellness Center will use the information for continuing medical care and may release the information to other providers involved in the care. I understand there may be a charge for my records. I further I authorize the above provider to release the information marked above.

_____ _____
Patient/Legal Respresentative or Parent/Legal Guardian Signature Date