



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME: _____		
	DOB: / /	PREVIOUS NAME(S): _____	
2. RELEASE MY RECORDS FROM	FACILITY NAME: _____		
	DR. NAME: _____		
3. SEND MY RECORDS TO	NAME: Preventive Cardiology Clinic		ATTN TO: _____
	ADDRESS: 4100 Minnesota Drive Suite 310		
	CITY: Edina	STATE: MN	ZIP: 55435
	PHONE: 952-929-5600		FAX: 952-929-5610
	UPCOMING APPT DATE: ____ / ____ / ____		
4. TYPES OF RECORDS	BODY PART: _____		
	DATE(S) OF SERVICE: _____		
	☐ Office Notes ☐ Hospital Reports ☐ Radiology Reports ☐ Therapy (Occupational or Physical) ☐ Lab Reports		
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____		
	"Verbal disclosure" authorizes PCC to discuss my care with the person(s) indicated in this section: _____		
6. REASON FOR REQUEST	☐ Personal Use ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care		
	Do you need imaging on a CD? ☐ Yes ☐ No		
7. RETURN COMPLETED FORMS TO:	MAIL TO: Preventive Cardiology Clinic 4100 Minnesota Dr #310 Edina, MN 55435		FAX TO: 952 – 929 – 5610 DROP OFF: Preventive Cardiology Clinic
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicated above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form.		
	SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.		

Electronic or Typed Signatures cannot be accepted