1300 Quincy Street NE, Ste 100
Minneapolis, MN 55413

Member Number: ________

Authorization for Release of Medical Records

I am under no obligation to sign this form in order to receive medical care. By signing this form, I am authorizing Doctor Sam to send my medical records to, or obtain my medical records from, the third party listed below. I understand that the records involved may contain sensitive information related to my physical and mental health including relevant history of infectious disease, mental health, and substance use or abuse. I understand that I may revoke this authorization at any time by written notification to Doctor Sam. My revocation will take effect on the date Dr. Sam receives it except as Dr. Sam has already acted in reliance upon this authorization. If I take no action, this authorization will expire 12 months after the date that I sign this form. I understand that when my medical records are released, they may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

PLEASE PRINT INFORMATION

Patient Name: ____

Address: ____

Date of Birth: ______________ Soc Sec #: ______________________ Phone #: ________________

Name of Organization You Are Requesting Records From: Doctor Sam, P.C.

Address: 1300 Quincy Street NE, Suite 100

City/State: Minneapolis/MN Zip: 55413

Phone: (612) 353-4034 Fax: (612) 353-4041

Name of Organization You Are Sending Records To: ______________________________

Address: ____

City/State: __________________________ Zip: ____________________

Phone: __________________________ Fax: ____________________

Records Being Requested: ____

Reason for Records Request: ____

Specific Dates Requested: ____

Signature of Patient or Patient Representative: ______________________ Date ____________