AALFA AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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Patient Information	Name: ______________________ Date of Birth: ____________ Address: ______________________ Day Phone: ____________ City: ______________________ State: ________ Zip: ____________
Clinic/ Health Care Provider (**Who** has the information you want released? Please be specific)	Name: ______________________ Fax Number: ____________ Address: ______________________ Day Phone: ____________ City: ______________________ State: ________ Zip: ____________
Receiving Party (**Where** do you want the information sent? **Who** may have the information?)	Name: ______________________ Attention to: ____________ Address: ______________________ Day Phone: ____________ City: ______________________ State: ________ Zip: ____________ Fax Number: ______________________
Information to be Released (**What** do you want sent or released? Check the appropriate box.)	Indicate Dates of Service: ______________ ☐ **Any and all clinic records** (Includes all types of records listed below) **ONLY** Record Types Checked Below: ☐ History & Physical Exam ☐ Radiology Reports ☐ Medication Records ☐ Progress Notes ☐ Pathology Reports ☐ Laboratory Reports ☐ Operative Reports ☐ Rehab Reports (PT/OT/ST) ☐ Consultations ☐ Chemical Dependency/ Substance Abuse Records ☐ Other (Please Specify): ______________________
Release Instructions (**How** and **When** do you want the information?)	Date Information is Needed: ____________ (Please allow 48 hours) **Release Method/ Format Requested:** ☐ **Paper** ☐ **Fax** ☐ **Verbal** Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F R. 164.524
Purpose of Release (**Why** is it needed?)	☐ Transfer of Medical Care ☐ Medical Treatment by Specialist ☐ Insurance ☐ Other (Please Specify): ______________________

- This authorization lasts for one year after the date signed unless you enter a different date of expiration here:
  ☐ Authorized for stated period: _________/_________/_________ through _________/_________/_________
- This authorization may be canceled at any time.
- AALFA health records may include records that we received from other organizations. If these records have been used by AALFA and filed in your AALFA record, these records may be released with your AALFA records.
- AALFA cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release AALFA from any and all liability resulting from redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

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Patient/ Legal Guardian **Date**