PREMIER WOMEN'S HEALTH OF MINNESOTA

Please Fax Completed form to 833-944-2004 or Email form to information@metropartnersobgyn.com

☐ I Hereby Authorize MetroPartners OBGYN Premier Women's Health of Minnesota to **REQUEST** information **FROM**:
Clinic/Hospital name:_____Fax #:_____

☐ I Hereby Authorize MetroPartners OBGYN Premier Women's Health of Minnesota to **RELEASE** information **TO**:
Clinic/Hospital name:_____Fax #:_____

☐ I Hereby Authorize MetroPartners OBGYN Premier Women's Health of Minnesota to **RELEASE** information **TO**: Myself (for personal file)

Patient will pick up records: YES NO If no, records should be: FAXED MAILED

Regarding the Following Patient:

Name _____ Date of Birth:_____

Other Names: _____ Phone Number:_____

Address: _____

INFORMATION REQUESTED

☐ Most recent 24 months ☐ Entire medical file ☐ Prenatal records

☐ Operative report & office notes for surgery on _____ (date)

☐ All records from _____ (date) through _____ (date)

☐ Other (describe) _____

PURPOSE OF RELEASE

☐ Continued Medical Care ☐ Transfer of Care ☐ Legal ☐ Insurance ☐ Other _____

This authorization expires on the following date, event or condition: _____
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:

- I understand that, except for research-related treatment, Premier Women's Health of Minnesota will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

* My insurer may share my past, current and future health and account records with Premier Women's Health of Minnesota about services I've received from Premier Women's Health of Minnesota and other care providers unrelated to Premier Women's Health of Minnesota. These records may be used by Premier Women's Health of Minnesota as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

* _____My insurer may not release any of my identifiable health records from providers unrelated to Premier Women's Health of Minnesota for the purposes described above.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Guardian Relationship to Patient Date