

**Clinic Sofia OB/GYN 6545 France Ave South, Suite 490, Edina, MN 55435**

Authorization and Consent to Disclose Information

Please fax Medical Record Release forms to **952-345-4448** or mail attention to Medical Records Department.  
Please allow seven to ten business days for us to prepare your records.

<b>Release From:</b> _____	<b>Release To:</b> _____
Clinic Name	
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Telephone Number	Telephone Number
_____	_____
Fax Number	Fax Number
_____	_____

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
<b>Telephone Number:</b> _____	<b>Pt ID#</b> _____
	(Clinic Use only)

If the request is for an appointment at another facility please indicate the date of your appointment: \_\_\_\_\_

**Would you like your records sent?** Mail \_\_\_\_\_ Fax \_\_\_\_\_ (will fax up to 25 pages)

I will pick up records at Clinic Sofia on this date: \_\_\_\_\_

**These records are to include reports dated:** From: \_\_\_\_\_ To: \_\_\_\_\_

Physician Notes   
 Pathology Reports   
 Mammogram Reports   
 HIV Test/ STD Test   
 Lab Reports  
 Bone Density Reports   
 Ultrasound Reports   
 Prenatal Records   
 **ALL RECORDS**

**Reason for Release:**

Transfer Clinic   
 Personal Use   
 Insurance Change   
 Ongoing Medical Care  
 Other \_\_\_\_\_

I understand that I may revoke this consent at any time and that the consent will automatically expire six months from the date of my signature.

I do not authorize further release to any third party. I understand that once information is released pursuant to this authorization, The Hospital, Clinic, their employees and my Physician(s) cannot prevent the redisclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by the consent.

Patient Signature: _____	Date: _____
Other Signature: _____	Date: _____

(Relationship to Patient, Reason Patient Unable to Sign) \_\_\_\_\_