Authorization and Consent to Disclose Information

Clinic Sofia will provide, as a courtesy, the last three years of records free of charge.

Please fax/or mail ATTN Medical Records Medical Record Release Form.
Note: Please allow seven to ten business days for us to prepare your records.

Release:

To -or- **From (←Circle One)**

(Select Location)

☐ **6545 France Ave South, Suite 490**
Edina, MN 55435
Fax 952.345.4448

☐ **15679 Grove Circle North**
Maple Grove, MN 55369
Fax 763.416.1758

To -or- **From (←Circle One)**

_____
Facility or Individual Name

_____
Mailing Address

_____
City **State** **Zip Code**

_____
Telephone Number

_____
Fax Number

Patient Name: _____ **Contact Phone Number:** _____

Date of Birth: _____ **Patient ID/(if known):** _____ **Requesting Doctor:**_____

These records are to include (list dates): From: _____ To: _____

☐ Physician Notes ☐ Pathology Reports ☐ Mammogram Reports ☐ Lab Reports ☐ Dexa Scans/Mammograms

☐ Ultrasound Reports ☐ **ALL RECORDS**

Reason for Release:

☐ Transfer Clinic ☐ Personal ☐ 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 re-disclosure 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 _____