Clinic Sofia
OBGYN, PA

Authorization and Consent to Disclose Information
Clinic Sofia OBGYN/PA

Phone: 952.922.7600 (p)
Email: sofia@clinicsofia.com

Release To / Release From: (designate which location)

☐ **6545 France Ave South, Suite 490**
Edina, MN 55435
Fax 952.345.4448 Phone 952.922.7600

☐ **15679 Grove Circle North**
Maple Grove, MN 55369
Fax 763.416.1758 Phone 952.922.7600

Release From / Release To: (complete below)

_____
Facility or Individual Name

_____
Mailing Address

_____
City State Zip Code

_____
Phone Number Fax Number

Patient Name: _____ MRN (if known): _____

Date of Birth: _____ Contact Number: _____

Information needed by (date): _____

Note: please allow seven to ten business days for Clinic Sofia to prepare records.

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

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

☐ Ultrasound Reports ☐ **ALL RECORDS (as a courtesy, typically only the past three years sent unless otherwise indicated)**

Reason for Release:

☐ Transfer Clinic ☐ Personal ☐ Insurance Change ☐ Ongoing Medical Care ☐ Other _____

I understand that by signing this form, I am requesting that the health information specified to be sent to the third party named. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named. If the organization, facility or professional named has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified is sent to the third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. This consent will end one year from the date the form is signed unless indicated.

Patient Signature: _____ Date: _____

Other Signature If Needed: _____ Date: _____

Relationship to Patient _____