Clinic Sofia
OBGYN, PA

Authorization and Consent to Disclose Information
Clinic Sofia OBGYN/PA

Phone: 952.922.7600 (p)
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To -or- From: (circle which location)

- ☐ **6545 France Ave South, Suite 490**
  Edina, MN 55435
- ☐ **15715 Grove Circle North**
  Maple Grove, MN 55369

To -or- From: (complete below)

_____
Facility or Individual Name

_____
Mailing Address

_____
City State Zip Code

_____
Phone Number Fax Number

Patient Name: _____ **Date of Birth:** _____

Patient Contact Number: _____ **MRN (if known):** _____

Information needed by date: _____ **Requesting Provider:** _____

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 _____

Requesting Physician's Signature: _____ Date: _____

Requesting Physician's Printed Name: _____