Authorization and Consent to Disclose Information

Clinic Sofia will provide, as a courtesy, the last three years of records free of charge. If you would like **more than the past three years of records**, there will be a **$1.10 per pg** processing fee, plus any additional postage to mail records.

Please fax Medical Record Release form to **952.345.4448** (Edina) or **763.416.1758** (Maple Grove)
or mail ATTN Medical Records. Please allow seven to ten business days for us to prepare your records.

Release: To 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

Release: From To (Circle one)
(Please complete below)

_____
Facility or Individual Name

_____
Mailing Address

_____
City State Zip Code

_____
Telephone Number Fax Number

Patient Name: _____ **Patient ID (if known): _____**

Date of Birth: _____ **Contact Number: _____**

If records are needed for a specific appointment date, what is that date of that appointment? _____

Would you like your records: Mailed Faxed Pick up at Clinic Sofia _____ (List date you will pick up)
(Note: We will only fax up to 25 pages)

These records are to include (list dates): 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 ☐ 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 _____