# METROPOLITAN PEDIATRIC SPECIALISTS, P.A.

*Pediatric and Adolescent Medicine*


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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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|---|---|
| ***INSTRUCTIONS*** | • Make sure all blanks are filled in. Failure to do so may delay this request.<br>• Please read the statement at the bottom about obtaining copies of medical records. |
| ***PATIENT IDENTIFICATION*** | Patient's Name(s):_____<br>Birthdate(s):_____ Phone:_____<br>Address:_____<br>_____<br>Parents/Guardian Name:_____ |
| ***PROVIDER*** (Who is releasing the information) | ☐ Metropolitan Pediatric Specialists, P.A.<br>**OR**<br>☐ Name and Address:_____<br>_____<br>_____ |
| ***REQUESTOR*** (Where do you want the information to be sent?) | ☐ Metropolitan Pediatric Specialists, P.A.<br>**OR**<br>☐ Name and Address:_____<br>_____<br>_____ |
| ***INFORMATION REQUESTED*** | ☐ Office Notes For Past 3 Years (includes items below)<br>☐ Immunization records ☐ Rehab/therapy summaries ☐ Hospital/surgical summaries<br>☐ Psychological reports/testing ☐ X-ray/lab reports ☐ Education testing results/reports<br>☐ Other/specify dates of service_____ |
| ***PURPOSE OF RELEASE*** | ☐ Insurance change/transfer ☐ Referral/consultation<br>☐ Mutual exchange of information ☐ Transferring out of clinic<br>☐ Other_____ |
| ***TIME LIMIT*** | I understand that this consent is valid for one year. It can be revoked at any time prior to this time period in writing and it will be effective on the date notified except to the extent action has already been taken in reliance on it. |
| ***TODAY'S DATE AND SIGNATURE*** | Signature:_____ Date:_____<br>Relationship to patient:_____ |

***RECORDS FROM OTHER FACILITIES:** It is our policy at Metropolitan Pediatric Specialists, P.A. to release only the medical information documented and/or dictated by our providers of service. If you have been treated at another health care facility or by another provider outside of this practice you need to contact them to release any information you may need.

- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that MPS may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand that in compliance with MN Statue 144.335 I may be required to pay a fee for retrieval and photocopying of records and/or supervising of medical records.
- I understand that a photocopy or fax of this form is the same as the original.