



# Metropolitan Pediatrics

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Edina**

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Edina, MN 55435  
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FAX: (952) 920-0232

**Lakeville**

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**Shakopee**

1515 St. Francis Avenue, Suite 100  
Shakopee, MN 55379  
Telephone: (952) 445-6700  
FAX: (952) 445-3527

<b>INSTRUCTIONS:</b>	Metropolitan Pediatrics, PA only releases medical information documented and/or dictated by the pediatricians that performed the service. If you or your child was treated at another health care provider outside this practice, please contact them to release any information you need. To avoid delays in completing your request, please complete each section.	
<b>PATIENT:</b>	Patient Name: _____	
	Date of Birth: _____	Phone: _____
	Address: _____	
	Parent/Guardian Name: _____	
<b>PROVIDER:</b> (Who is releasing the information?)	<input type="checkbox"/> Metropolitan Pediatrics, PA; or	
	Name: _____	
	Address: _____	
<b>REQUESTOR:</b> Where do you want the information sent?	<input type="checkbox"/> Metropolitan Pediatrics, PA; or	
	Name: _____	
	Address: _____	
<b>INFORMATION REQUESTED:</b>	<input type="checkbox"/> Immunization records <input type="checkbox"/> Office notes <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Psychological reports/tests <input type="checkbox"/> Education testing reports <input type="checkbox"/> Other/specify dates of service: _____	
<b>PURPOSE OF RELEASE:</b>	<input type="checkbox"/> Insurance change/transfer <input type="checkbox"/> Referral/consultation <input type="checkbox"/> Transfer out of clinic <input type="checkbox"/> Mutual exchange of information <input type="checkbox"/> Other; please specify: _____	
<b>CONSENT:</b>	<ul style="list-style-type: none"> <li>• I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and no longer be protected by Federal privacy regulations.</li> <li>• I understand that Metropolitan Pediatrics, PA may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.</li> <li>• I understand that in compliance with MN Statute 144.335 I may be required to pay a fee for retrieval and photocopying of records and/or supervising of medical records.</li> <li>• I understand that a photocopy or fax of this form is the same as the original.</li> <li>• I understand this consent is valid for one year. It can be revoked at any time prior to this timer 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.</li> </ul>	
<b>SIGNATURE:</b>	Signature: _____	Date: _____
	Relationship to Patient: _____	