

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize certain protected health information (PHI) about me to be released.

Records to be released from:

Records to be sent to:

John A. Haugen Associates, P.A.
Name/Organization

Name/Organization

801 Nicollet Mall, Suite 400
Street Address

Street Address

Minneapolis, MN 55402
City/State/Zip

City/State/Zip

The following information is to be released/reviewed (check appropriate boxes):

- History and Physical Exam Discharge Summary Operative Reports Emergency Department Reports
- Hospital Outpatient Reports Laboratory Reports Pathology Reports X-ray/Radiology Reports
- Films Consultation Reports Clinic Notes Other _____

Release records from date _____ **to** _____

The information will be used or disclosed for the following purpose:

- Continued care for ongoing treatment Transfer of Care Attorney review Insurance claim purposes
- Personal Use Other _____

This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here:

I do not have to sign this authorization in order to receive treatment from John A. Haugen Associates, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address listed above.

Signed by: _____
Signature of Patient or Legal Guardian

Date of Signature

Please Print Name

Social Security Number

Previous Names

Date of Birth

Home Phone Number

Work/Cell/Other Phone Number