

**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:

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

801 Nicollet Mall, Suite 400  
Street Address

Minneapolis, MN 55402  
City/State/Zip

Records to be sent to:

\_\_\_\_\_  
Name/Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
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:**

- Transfer of Care:       Provider/care change       Dissatisfaction with care       Geographic relocation
- Continued care for ongoing treatment       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