

**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:

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

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

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

801 Nicollet Mall, Suite 400  
Street Address

\_\_\_\_\_  
City/State/Zip

Minneapolis, MN 55402  
City/State/Zip

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

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> History and Physical Exam   | <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Emergency Department Reports |
| <input type="checkbox"/> Hospital Outpatient Reports | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> X-ray/Radiology Reports      |
| <input type="checkbox"/> Films                       | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Clinic Notes      | <input type="checkbox"/> Other _____                  |

**Release records from date** \_\_\_\_\_ **to** \_\_\_\_\_

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Continued care by another provider | <input type="checkbox"/> Attorney review | <input type="checkbox"/> Insurance claim purposes |
| <input type="checkbox"/> Personal Use                       | <input type="checkbox"/> 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