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:

____
Name/Organization

____
Street Address

____
City/State/Zip

Records to be sent to:

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

2805 Campus Drive, Suite 315
Street Address

Plymouth, MN 55441
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 by another provider ☐ 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