



Family Tree Clinic
 1619 Dayton Avenue #205
 St. Paul, MN 55104
 Phone: (651) 645-0478
 Fax: (651) 642-2523

Please allow
 7-10 days
 for processing

Authorization for Release of Medical Records

Patient's Last Name _____ First Name _____ MI _____

Family Tree # _____ Date of Birth ____/____/____ Patient's Phone #(____)____ -- _____

Patient's Address _____

City State Zip

Maiden Name _____ Social Security # _____ - _____ - _____

I authorize the Family Tree Clinic to:

| | |
|---------------------------------|-----------------------|
| _____ Send medical records to: | Name of clinic |
| _____ Get medical records from: | Address |
| | City, state, zip code |
| | PHONE # _____ |
| | FAX # _____ |

Please mark which medical records you are requesting, *be as specific as possible.*

| | |
|---|---|
| Visit notes <i>dates</i> _____ | Sexually Transmitted Infection tests <i>dates</i> _____ |
| Pap Smear/Colposcopy/Pathology Results <i>dates</i> _____ | Other tests _____ <i>dates</i> _____ |
| Depo Injection Records <i>dates</i> _____ | Billing/Invoices <i>dates</i> _____ |
| Other: _____ | |
| _____ | |

Needed for an appointment on this date: _____

I understand this authorization will expire in one year and that I can revoke this authorization with a written request.

I understand that once information is released pursuant to this authorization, Family Tree Clinic cannot prevent the redisclosure of the information to another third party for the purposes of treatment.

Patient Signature _____ Date _____

Office Only

Date Records/Request sent _____ Staff Initials _____

Date Records Received _____ Staff Initials _____

