MINNESOTA BIRTH CENTER

Please email completed form to info@theminnesotabirthcenter.com

2606 Chicago Ave S Minneapolis, MN 55407 Ph: (612) 545-5311
624 Smith Ave S St. Paul, MN 55107 Ph: (651) 689-3988
Fax: (612) 224-9622

Authorization to Request Health Information

I authorize Minnesota Birth Center (MBC) to: □ **receive** // □ **send** the health information of the individual named at right:	**Patient Information** **DOB: _____ MBC Client #: _____** Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Email: _____
Send: □ From Provider □ To Provider □ To Self	**Clinic or Provider Information** Name: _____ Address: _____ Suite: _____ City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ Email (required if emailing): _____ Send via: □ Fax (recommended) □ Paper print out □ Email
Information to be Released *The type and amount of information to be released to/from MBC is as follows (specify dates where appropriate):*	❑ Entire prenatal record current pregnancy ❑ Lab Results past 2 years ❑ Imaging/Ultrasound reports past 2 years ❑ Most recent 1, 3, 5 years of record ❑ Genetic Testing, from date _____ to date _____ ❑ Immunizations ❑ HIV / AIDS information, from date _____ to date _____ ❑ Medical Records for Diagnosis of _____ Treating Provider: _____ ❑ For the time period of _____ to _____ ❑ Other _____
Reason for Release	❑ Transferring care ❑ My own personal use ❑ Legal use Other: _____

- I understand that the medical information released by this authorization may include information related to the treatment of physical and mental illness, alcohol/drug abuse and medical history.
- I understand this authorization will expire without my express revocation, either one year from the date signed or if I am a minor, on the date I become an adult per state law. I understand that I may revoke this authorization in writing at any time except to the extent for actions that were already taken per this request. I understand that revocation will not apply to information that has already been released as specified by this request or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign. MBC cannot condition treatment except as otherwise permitted by law. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Authorized Personal Representative Date

Revised 5/22/17