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Authorization to Request Health Information

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