

Clinic Sofia OB/GYN 6545 France Ave South, Suite 490, Edina, MN 55435

Authorization and Consent to Disclose Information

As a courtesy, Clinic Sofia will provide the last three years of records free of charge. If you would like **more than the past three years of records**, there will be **\$1.10 per pg** processing fee, plus any additional postage to mail records.

Please fax Medical Record Release form to **952-345-4448** or mail ATTN Medical Records. Please allow seven to ten business days for us to prepare your records. Filling out this form **completely** (i.e. address, phone and fax number of where records are being sent) allows for quicker processing time.

Release From: _____ Clinic Name	Release To: _____ Clinic Name
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Telephone Number Fax Number	Telephone Number Fax Number

Patient Name: _____ **Date of Birth:** _____

Contact Number: _____

If records are needed at another facility for a specific appointment, what is the date of that appointment? _____

Would you like your records (circle choice): Mailed Faxed Pick up at Clinic Sofia _____
(Note: We will only fax up to 25 pages) (List date you will pick up)

These records are to include (list dates): From: _____ To: _____

- € Physician Notes € Pathology Reports € Mammogram Reports € HIV Test/ STD Test € Lab Reports
- € Bone Density Reports € Ultrasound Reports € Prenatal Records € **ALL RECORDS**

Reason for Release:

- € Transfer Clinic € Personal € Insurance Change € Ongoing Medical Care € Other _____

I understand that I may revoke this consent at any time and that the consent will automatically expire six months from the date of my signature.

I do not authorize further release to any third party. I understand that once information is released pursuant to this authorization, The Hospital, Clinic, their employees and my Physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by the consent.

Patient Signature: _____ Date: _____

Other Signature: _____ Date: _____

Relationship to Patient _____