InterMed Consultants
Specialists in Kidney and Infectious Diseases

Authorization for Disclosure of Protected Health Information

Clinic use only
Received:
Date: _____ **Initials:** _____ **Ext.** _____

Health Information Dept use only
Processed by: _____

Items Sent: ❑ **All Requested** ❑ **Partially fulfilled (see Response to Records Request form)**

Instructions: *Any incomplete section invalidates this form and the request cannot be processed.*

Patient Name (First, Middle, Last)			Patient DOB (Month, DD, YYYY)
Mailing Address of Patient - Street			
City	State	ZIP Code	Phone

Release Information From

❑ **InterMed Consultants**
6600 France Avenue South • Suite 162 • Edina, MN 55435
Tel: 952-920-2070 **Fax: 952-920-7444**

❑ **Specify Facility Name & Address below, including phone/fax**

Name of Dr. or facility: _____

Address: _____

Phone: _____

Fax: _____

Release Information To

❑ **InterMed Consultants**
6600 France Avenue South • Suite 162 • Edina, MN 55435
Tel: 952-920-2070 **Fax: 952-920-7444**

❑ **Specify Facility Name & Address below, including phone/fax**

Name of Dr. or facility: _____

Address: _____

Phone: _____

Fax: _____

Information to be Released (Include dates of service if known; if no date of service included you will receive a year of records)

❑ Office Notes ❑ Pathology ❑ Lab Reports ❑ Radiology Reports

❑ Other (specify content & dates) _____

Information Needed By (specify date) _____

All information regarding HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:

_____ Do not release HIV/AIDS records

Purpose of Release

❑ Treatment / Continued Care ❑ Disability Determination ❑ Insurance Purposes

❑ Personal Use ❑ Litigation ❑ Other (please explain) _____

_____

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective the date notified except to the extent action has already been taken in reliance on it. I understand that InterMed Consultants may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization. I understand a photocopy or fax of this form is the same as the original.

I understand the expiration date of this authorization is 1 year from the date of signing unless I indicate on earlier date or event here.

_____

Patient or Legal Representative Signature	**Date Signed (Month, DD, YYYY)**
Printed Name of Patient or Legal Representative	