AUTHORIZATION FOR RELEASE OF INFORMATION
From: AALFA Family Clinic

Paul Spencer, D.O.
Mary Paquette, M.D.
Matthew Paquette, M.D.
Kathleen Kobbermann, M.D.
Matthew Anderson, M.D.
Cheryl McKee, PA-C, MPAS

4465 White Bear Parkway
White Bear Lake, MN 55110
651/653-0062
fax 651/653-0288
www.aalfafamily.com

_____

Patient Last Name First Name Middle Initial Maiden Name

Date of Birth: _____ Social Security Number (optional) _____

I hereby authorize AALFA Family Clinic to furnish information from Medical Records to:

Facility/Doctor: _____

Phone #: _____ Fax #: _____

Address/Location: _____

_____

Information to be released:

- ☐ Laboratory Reports, only
- ☐ All/any medical information present in any medical record (including treatment for mental health, chemical dependency and HIV status).
- ☐ Selected medical information about: _____

_____

Time period for information that is to be released: _____

☐ Prior 6 month period ☐ Prior 12 month period ☐ All dates of service

Information is needed for the purpose of:

- ☐ Transfer of medical care
- ☐ Insurance
- ☐ Legal
- ☐ Medical treatment by outside specialist
- ☐ Family member access
- ☐ Other (please specify) _____

I understand that I may revoke this consent at any time except to the extent it has been acted upon and that upon fulfillment of the above stated purpose or one year from this date (whichever occurs first), that consent will automatically expire without my express revocation. I do not authorize re-release of chemical dependency-related information by the party receiving it.

I also understand that I am responsible for any charges associated with the transfer of this information.

Signature _____ _____

Patient (or Parent or Guardian) *Date*

_____ _____

Relationship to Patient *Witness*

© AALFA Clinic Protocol, Policy and Process Manual