AALFA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Personal, Legal, or Foreign Language Translator and/ or Interpreter Service

4465 White Bear Parkway
White Bear Lake, MN 55110
P: 651.653.0062 F: 651.653.0288

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Receiving Party (Who would you like AALFA to release your information to?)	Name: _____ Relationship: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Information to be Released (Whomever you designated as receiving party will have access to all records you allow.)	Indicate Dates of Service: _____ ☐ **Any and all clinic records** (The following records **WILL** be included if not marked as an exclusion below - mental health, chemical dependency, HIV status, pregnancy, drug testing results) **Exclusions:** ☐ Treatment for Mental Health ☐ Pregnancy ☐ Chemical Dependency ☐ HIV Status ☐ Drug Testing Results ☐ Other (Please Specify):
Purpose of Release (Why is it needed?)	☐ Personal ☐ Legal ☐ Foreign Language Translator Service

- This authorization lasts for one year after the date signed unless you enter a different date of expiration here:
  ☐ Authorized for stated period :_____/_____/_____ through _____/_____/_____
- This authorization may be canceled at any time.
- AALFA health records may include records that we received from other organizations. If these records have been used by AALFA and filed in your AALFA record, these records may be released with your AALFA records.
- AALFA cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release AALFA from any and all liability resulting from redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____

Patient/ Legal Guardian **Date**