Bluestone Physician Services - Authorization for Release of Health Information

Patient Information: *Please use full legal name*

Last Name: _____ First Name: _____ M.I. __ Date of Birth: __/__/_____

Community: _____

Release Information From *(Required):

Clinic Name: _____

Phone: _____

Fax: _____

Address: _____

_____

City: _____State: _____ Zip: _____

Release Information To:

☐ Bluestone Physician Services

Attn: Medical Records Dept.
270 Main Street N.
Suite 300
Stillwater, MN 55082

FAX: 855-490-4045
PHONE: 651-342-4275

Information To Be Released *(Required): *Indicate ONLY the information that you are authorizing to be released.*

☐ **ALL HEALTH INFORMATION** ☐ CD of Images ☐ Specific dates/years of treatment _____

OR Release Indicated Records only:

☐ History Form	☐ Doctor/Visit Notes	☐ Laboratory Reports	☐ Operative Reports
☐ Test Results	☐ ED/ER Records	☐ Hospital Records	☐ Discharge Summary
☐ Medication History	☐ Radiology Reports	☐ Therapy Notes	☐ Radiology Images
☐ Billing Statements	☐ Procedure Records	☐ Other Information/Instructions_____	

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

Chemical dependency program: Yes_____ No_____ Psychotherapy notes: Yes_____ No_____

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent will expire one year from the date it is signed unless I write in a specific expiration date here: _____.

_____ _____

Patient or Legal Representative Signature **Date**

_____

Legal Representative Printed Name and Authority to sign for patient (i.e. Health Care Directive, Medical POA –*must include documentation)*

Fax Completed Forms To: **MN**: 855-306-1167 **WI**: 888-972-8297 **FL**: 855-523-3935