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:

Bluestone Physician Services
270 Main Street N., Suite 300
Stillwater, MN 55082

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

## *Release Information To (Required):

Clinic Name: ____________________________________________

Address: ____________________________________________

City: ______________________ State: ________ Zip: ___________

Phone: ______________________ Fax: ______________________

## *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:** 877-916-7631