General Medical Records Release
Authorization for Use or Disclosure of Protected Health Information

A copy of this signed authorization must be given to the individual.

Please complete the following information:

Patient Name: _____

Address: _____
Street City State ZIP

Phone: _____SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Other (describe specifically)_____
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Pharmacy/prescription records

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug /alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):_____

Please send the records listed above to:

Name: **Kimberly A. Carlson, CMT** **Health Enhancement Therapies**
Provider Name Facility/Clinic Name
Address: **205 County Road 119** **Saint Michael** **MN** **55376-9272**
Street City State ZIP
Phone: **612-716-6199** Fax: **763-420-5562**

The information may be used / disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For payment/insurance
- ☐ Other: _____
- ☐ For my health care
- ☐ For employment purposes

☐ **I authorize the above mentioned provider to release medical records regarding treatment to:**

Name: _____
Provider Name Facility/Clinic Name
Address: _____
Street City State ZIP
Phone: _____ Fax: _____

This authorization shall expire on: _____/_____/_____ or upon the following event_____ (whichever is sooner), and may not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information that it will still be protected by HIPAA Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient (or patient's personal representative) Date

_____
Printed name of patient OR representative Representative's authority to sign for patient
(i.e parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the provider(s) indicated above.