

**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

I hereby authorize the release of my health information

**FROM:**

Clinic/Provider: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TO:**

Boynton Health Service, Occupational Health

410 Church St SE

Minneapolis, MN 55455

Phone: (612) 626-9423 Fax: (612) 624-3310

I specifically authorize the release of the following information: **immunization records** \_\_\_\_\_

Reason for release of Information: **To complete occupational health requirements** \_\_\_\_\_

**PATIENT IDENTIFYING INFORMATION**

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name (Please Print) \_\_\_\_\_ Maiden/former/alias: \_\_\_\_\_

Student/Employee ID # \_\_\_\_\_ Boynton Medical Record # \_\_\_\_\_

Address: \_\_\_\_\_

Telephone - Home: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_\_ Work: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_\_

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- Your treatment will not be conditioned on your signing this authorization except for research-related treatment.
- You are entitled to a copy of this *Authorization for the Release of Health Information*.

\_\_\_\_\_  
Signature of Patient/Authorized Person  
(If authorized person signing, also print name.)

\_\_\_\_\_  
Authorized Person's authority to sign  
(Parent, guardian, power of atty., etc.)

\_\_\_\_\_  
Date

REASON PATIENT IS UNABLE TO SIGN:  Minor  Deceased  Other \_\_\_\_\_

**OFFICE USE ONLY** Received by: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date sent to Info.Desk: \_\_\_\_\_ Date Mailed: \_\_\_\_\_

Completed Form filed in Medical Record by: \_\_\_\_\_

**Please Fax Copies of Immunization Records to:  
(612) 624-3310, Attn: ROHP**