

AUTHORIZATION TO RECIEVE MEDICAL INFORMATION



RELEASE TO:		RELEASE FROM:	
Name MINNESOTA HEART CLINIC		Name	
Address 6405 FRANCE AVE S, SUITE W200		Address	
City, State, & Zip EDINA, MN 55435		City, State, & Zip	
Phone No. 952-836-3700	Fax No. 952-836-3903	Phone No.	Fax No.

You are hereby authorized to release the following records to MN Heart Clinic for:

Patient Name	
Date of Birth	Phone No

- Stephen C. Battista, M.D.
- Norman P. Chapel, M.D.
- Gary H. Cramer, M.D.
- C. Jennifer Dankle, D.O.
- Laura A. Diamandopoulos, M.D.
- Candace D. Dick, M.D.
- James W. Erdahl, M.D.
- Eric R. Ernst, M.D.
- Karl W. Foster-Smith, M.D.
- Steven M. Heifetz, M.D.
- Gregory A. Helmer, M.D.
- Brian H. Ip, M.D.
- Demosthenes N. Iskos, M.D.
- Robert A. Ketrosier, M.D.
- David D. Laxson, M.D.
- Brian T. Lew, M.D.
- Huagui Li, M.D., Ph.D.
- Michael J. Manoles, M.D.
- Quan V. Pham, M.D.
- Dominic A. Plucinski, M.D.
- Tushar R. Vora, M.D.

TREATMENT DATES From _____ To _____

Any and all medical records, including reports involving alcohol, drug abuse, HIV status, psychiatric Treatment.

OR:

- | | |
|--|--|
| <input type="checkbox"/> Office visits | <input type="checkbox"/> Hospital Consultation |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Procedure/Operative Reports |
| <input type="checkbox"/> Holter/Event Monitors | <input type="checkbox"/> Device Clinic Reports |
| <input type="checkbox"/> Nuclear Testing | <input type="checkbox"/> Stress Test/Treadmill |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stress Echocardiogram | |

REASON FOR RELEASE:

- Appointment, date: _____
- Other (Specify) _____

I understand that Minnesota Heart Clinic will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations.

- If the medical information to be disclosed will result from treatment for research purposes, Minnesota Heart Clinic will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Minnesota Heart Clinic will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to Minnesota Heart Clinic's Privacy Officer. If I revoke this authorization, Minnesota Heart Clinic will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Minnesota Heart Clinic discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

Under Minnesota law, this authorization will expire one year from the date the authorization is signed, unless the authorization is to release information to a current treatment provider, third-party payor, or a researcher.

I understand and agree to the terms of this authorization.

Signature of Patient/Parent/Guardian

Date

Relationship to Patient

Reason Patient is Unable to Sign

Edina
(952) 836-3700
Fax (952) 836-3903
6405 France Ave. South
Suites W200 & W300
Edina, MN 55435

Other offices in Burnsville,
Princeton and Wyoming

For appointments at all
locations, call (952) 836-3770

