

AUTHORIZATION TO RELEASE MEDICAL INFORMATION



RELEASE FROM:		RELEASE TO:	
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 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.

TREATMENT DATES From _____ To _____

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. Ketroser, M.D.
 David D. Laxson, M.D.

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"/> Diagnostic Reports performed at MHC | <input type="checkbox"/> Device clinic follow-up visits |
| <input type="checkbox"/> Nuclear Testing | <input type="checkbox"/> Procedure/Operative Reports |
| <input type="checkbox"/> Holter Monitor | <input type="checkbox"/> ECP |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Bio-Z |
| <input type="checkbox"/> Stress Test/Treadmill | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Echocardiogram | _____ |
| <input type="checkbox"/> Stress Echocardiogram | _____ |

Brian T. Lew, M.D.
 Huagui Li, M.D., Ph.D.
 Michael J. Manoles, M.D.

REASON FOR RELEASE:
 Appointment, Date: _____
 Other (Specify) _____

Quan V. Pham, M.D.
 Dominic A. Plucinski, M.D.
 Tushar R. Vora, M.D.
 Larry Gunderson, CMA, MBA
 Executive Director

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.

In Memoriam:
 Thomas F. Cheng, M.D.
 1953-2008

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

