Lakeview Clinic Ltd.

Authorization To Release Protected Health Information

Patient Name(s) / Date of Birth _____

_____

_____

Healthcare Facility Authorized to Release Information _____

_____

_____

Name/Organization Receiving Information _____

_____

_____

Specific medical information requested, include dates of service: _____

_____

_____

Specific purpose of request for release of protected health information: _____

_____

_____

I understand this release will take effect on the date signed and will be in effect for one year. I understand that I may cancel this release at any time by notifying Lakeview Clinic, Ltd. in writing and my cancellation will take effect when Lakeview Clinic, Ltd. receives written notice. Any release made prior to receipt of a written cancellation shall be deemed valid. A photocopy of this authorization will be treated in the same manner as the original. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA. I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment). We require at least 10 business days to process this form.

_____ _____ _____

Signature of Patient/Legal Representative | Authorized Person's authority to sign (parent, guardian, power of attorney, etc.) | Date

424 State Hwy 5 W
Waconia MN 55387
952-442-4461*Fax 952-442-2970

110105 Pioneer Trail
Chaska MN 55318
952-556-0120*Fax 952-556-0121

309 Jefferson Ave SW
Watertown MN 55388
952-955-1921*Fax 952-955-3115

406 Faxon Rd
Norwood MN 55368
952-467-2888*Fax 952-467-3258