GERTEN
UROGYNECOLOGY

Internal Use Only | Account #_____

Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:		
	DOB: / /	PREVIOUS NAME(S):	
2. RELEASE MY RECORDS FROM	FACILITY NAME:		
	DR. NAME:	PHONE:	FAX:
3. SEND MY RECORDS TO	NAME:	ATTN TO:	
	ADDRESS:		
	CITY:	STATE:	ZIP:
	PHONE:	FAX (For Continuing Care ONLY):	
	Email: (Only if you want records sent via encrypted email)		
4. TYPES OF RECORDS	DATE(S) OF SERVICE:		
	☐ All Health Information (not including billing) ☐ Office Notes ☐ Radiology Reports	☐ Lab Reports ☐ Operative Reports ☐ Hospital Reports ☐ Billing Statement	☐ Pathology Reports ☐ Other:
5. REASON FOR REQUEST	☐ Personal Use ☐ Disability	☐ Insurance ☐ Legal	☐ Workers Compensation ☐ Continuing Care
6. RETURN COMPLETED FORMS TO:	**MAIL TO OR DROP OFF:** Gerten Urogynecology 6565 France Ave S, Suite 200 Edina, MN 55435	**EMAIL TO:** info@obgynpa.com **FAX TO:** 952 – 920 – 0866	
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		

7. I UNDERSTAND THAT BY SIGNING THE BELOW:

- I may revoke this authorization at any time by notifying i-Health in writing. If I revoke this authorization, i-Health will no longer use or disclose my health information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization.
- By authorizing the release of my protected health information, the health information may no longer be protected and has the potential to be re-disclosed.
- There may be a fee for release of this information and I may be responsible for that fee.
- I am authorizing the release of my personal protected health information from any i-Health facility, unless otherwise specified above.
- Treatment will not be denied to me if I do not sign this form.
- This authorization will expire one year from the date I sign this form, unless specified: _____
- If I provided an email address in section 3, I understand that the requested records will be sent via encrypted email, or it may be sent to a patient portal
- i-Health is a multispecialty practice including, and without limitation, the clinic above. Your i-Health record will be released, unless you otherwise specify in writing

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

*If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.

Electronic Typed Signatures cannot be accepted