

STONE CREEK PSYCHIATRY
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER: (Home) _____ (Work) _____ (Other) _____

1. Please Release my records/communications FROM: _____ (or check here to EXCHANGE WITH)

____ Stone Creek Psychiatry: (listed above)
 ____ Clinic, Organization or Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

2. Please release my records/communications TO:

____ Stone Creek Psychiatry: (listed above)
 ____ Clinic, Organization or Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

3. Information to be released: Any and all pertinent records (including all items below) OR check all that apply

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Discharge summary/note | <input type="checkbox"/> Lab reports | <input type="checkbox"/> Mental Health records | <input type="checkbox"/> Provider form |
| <input type="checkbox"/> History & Physical exam | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Chemical Dependency/Substance Abuse records | <input type="checkbox"/> FMLA paperwork |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Operative reports | <input type="checkbox"/> AIDS/HIV records | |
| <input type="checkbox"/> Progress/clinic notes | <input type="checkbox"/> Emergency records | <input type="checkbox"/> Genetic conditions record | |
| <input type="checkbox"/> Case manager reports | <input type="checkbox"/> Rehab records (pt/ot) | <input type="checkbox"/> Medication records | |
| <input type="checkbox"/> Psychological tests/summaries | <input type="checkbox"/> Other _____ | | |

ALL DATES: _____ SPECIFIC DATES: _____

4. I am requesting this information /authorization be released for the following purpose(s):

- | | | |
|---|---|---|
| <input type="checkbox"/> Transfer of care with another provider | <input type="checkbox"/> Litigation/Legal/Attorney review | <input type="checkbox"/> Verbal communication |
| <input type="checkbox"/> Coordination of care | <input type="checkbox"/> Personal use | <input type="checkbox"/> Billing purposes |
| <input type="checkbox"/> Insurance claim/application purposes | <input type="checkbox"/> Social Security Disability Determination | <input type="checkbox"/> Work related |
| <input type="checkbox"/> Social Security Appeal | <input type="checkbox"/> Other _____ | |

I understand the following:

I may revoke this authorization at any time by writing to the address listed 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 automatically expire one year from the date of my signature or at the date I specified here _____. I understand that once information is released pursuant to this authorization Stone Creek Psychiatry cannot prevent the re-disclosure of this information to another third party.

A signed copy of this form is considered valid if it has not been altered. Your signature indicates that you have read and understand this form and authorize release of your information as described above.

 Signature of Patient/Authorized Person DATE: _____

 Authorized Person's Authority to Sign DATE: _____
 REASON PATIENT IS UNABLE TO SIGN: MINOR DECEASED OTHER _____