WAYZATA COSMETIC SURGERY & Spa

Records Release

Authorization for Use of Protected Health Information

Patient Name: _____

Address: _____

_____

Phone: ( ) _____ - _____

Date of Birth: / /

*I authorize the custodian of records of above person to disclose/release the following information

(check all applicable):

- ❑ All records
- ❑ Laboratory/Pathology records
- ❑ Pharmacy/Prescription records
- ❑ Surgical/Other records (specify)

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Requested Records From:

Wayzata Cosmetic Surgery & Spa

1421 Wayzata Blvd. E Suite #200

Wayzata, MN 55391

P: 952-473-6642/F: 952-473-2312

Release/Send Records To: _____

_____

_____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of Patient *(or patient's personal representative):* _____

Printed Name of Patient: _____

Date: / /

Representative's authority to sign for patient (guardian, executor, parent): _____