EDGEWATER
NATURAL FAMILY MEDICINE

22 Wilson Ave
Suite 205
St Cloud, MN 56304
P) 320-253-4112
F) 320-253-4116
www.edgewatermed.com

510 22nd Ave E
Suite 202B
Alexandria, MN 56308
P) 320-219-6800
F) 320-219-6801

Patient Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the listed health practitioner as described below to the requesting practitioner.

Patient Information:

Name of Patient: _____Date of Birth: _____

Address: _____

City: _____State: _____Zip: _____

Phone: _____ Social Security Number_____-_____-_____

Records to be released from:

Doctor's Name: _____Clinic Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone: _____Fax: _____

I authorize the above heath practitioner to release and/or disclose the medical information as indicated below to **Edgewater Natural Family Medicine (Please check a doctor AND a location)**

☐ Dr. Lee Aberle, ND, IFMCP
☐ Physical: 22 Wilson Ave NE, #205, St. Cloud, MN 56304
Postal: PO Box 6007, St. Cloud, MN 56302-6007
P) 320.253.4112 F) 320.253.4116

☐ Dr. Carly Erickson, ND, MSM, IFMCP
☐ 510 22nd Ave E, Suite 202B
Alexandria, MN 56308
P) 320-219-6800 F) 320-219-6801

Information to be released:

Laboratory tests from _____ to _____ Imaging reports from _____ to _____

Other_____ ___ Complete vaccine record

___ The most recent 3 years of pertinent objective information including labs, imaging reports, special tests, most recent treatment plans and SOAP notes, and other diagnostic reports.

Reason for Disclosure: ☐ Continuing Care ☐ Referral ☐ Personal ☐ Relocating ☐ Disability

☐ Legal/Attorney ☐ Patient Review ☐ Other_____

Patient Authorization: *I understand that in compliance with Minnesota Statutes which require special permission to release otherwise privileged information, please release records pertaining to Alcohol Abuse or test results, Drug Abuse or test results, Mental Health, Developmental Disabilities, HIV test results, AIDS or AIDS-related disease, Sexually transmitted disease, and/or Sickle Cell Information or test results. I give my specific authorization for these records to be released.*

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(date), or for 1 year from the date of signature (leave blank if unsure).

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before written revocation was received.

RE-DISCLOSURE: If your health information is re-disclosed it is no longer protected under HIPAA. Any information so used or authorized may be subject to re-disclosure by the recipient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes

Signature: _____ Date: _____

Patient, guardian, or authorized Representative

All patient information is handled under the HIPPA privacy Act.
Possible copying fee required.