AUTHORIZATION FOR COORDINATION OF PROTECTED HEALTH INFORMATION (PHI)

❶ PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth

❷ CURRENT OR FORWARDING ADDRESS AND TELEPHONE:

____
Street Address City State Zip Code Phone

❸ PRIMARY CARE PHYSICIAN:

____ @Wayzata Children's Clinic

____
Site Location Phone Fax

Minnetonka@ WCClinic.org ______________________________________
Secure Email

❹ MENTAL HEALTH PROVIDER:

____
Clinic or Individual's Name Phone Fax

____
Street Address City State Zip Code

____
Secure Email

❺ RELEASE FORMAT:

- ❑ **Written Communication (Fax, Mail, Secured Email)**
- ❑ **Verbal Communication (Telephone)**

❻ DATE INFORMATION NEEDED:______________________________________

❼ DISCLOSURE INFORMATION REQUESTED

- ❑ Clinic visit notes, Lab/Diagnostic Testing Results, Medication list
- ❑ Mental health/Psychological Consults/Results
- ❑ Summary of Treatment records & Contact Dates
- ❑ Other (please specify)

❽ DISCLOSURE DIRECTION:

- ❑ Wayzata Children's can Exchange the Information indicated above
- ❑ Wayzata Children's will Receive the information indicated above
- ❑ Wayzata Children's will Release the information indicated above

❾ AUTHORIZATION:

I understand that Wayzata Children's Clinic, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form. I must sign in order to release my protected health information. This authorization is valid for information disclosed for purpose of treatment, payment and health care operations **for one year unless otherwise specified**. I understand that I can revoke this authorization at any time in writing. I understand that once information is released pursuant to this authorization, Wayzata Children's Clinic, P.A. cannot prevent the redisclosure of the information to another third party.

____
Signature of Patient or Guardian Printed Name Relationship Date

(Patients 18 years or older are legally required to sign any/all authorizations)