PERMISSION TO SEND HEALTH INFORMATION TO BHATTI GI CONSULTANTS, P.A.

Use this form when you want a health care provider to send your medical records.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( )

Address: _____

City: _____ State: Zip:

SENDER

I authorize:

Name of Provider: _____

Street Address: _____ Fax Number: ( )

City: _____ State: Zip:

RECIPIENT

To share (disclose) my health information with Bhatti GI Consultants, P.A.
Send to: Bhatti GI Consultants, P.A. 1457 White Oak Drive, Chaska MN 55318
Phone: 952-368-3800 Fax: 952-368-3801

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

- ☐ Discharge Summary
- ☐ Emergency Department Reports
- ☐ Immunizations
- ☐ Inpatient Progress Notes
- ☐ Laboratory/Pathology reports
- ☐ Operative Reports
- ☐ Outpatient Visit (Office) Notes
- ☐ School physical forms
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Other _____
- ☐ Records from a specific provider: _____

For the following purpose: _____

SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Bhatti GI Consultants, P.A. at the location noted above UNLESS I place my initials in the applicable space next to the type of records:**

- _____ Mental health treatment records
- _____ Sexually Transmitted Disease (STD) treatment records
- _____ Genetic testing
- _____ Alcohol/drug abuse treatment records
- _____ HIV/AIDS test results

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Bhatti GI Consultants, P.A. and _____ will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. Your sending health care provider may require fees to process your request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**