ROI – Release of Information to DPC
Authorization for Release Health of Information

Patient Information:	Name: ______________________________ Maiden Name/Alias: ___________________________ Date of Birth:______/______/______ Social Sec: ____________________________ Phone:____ MR#_________________
Health Information Released **FROM**:	☐ Other Person/Organization:____ Street Address:____ City/State/Zip:____ Fax:________________________ Phone: _____________________________
Health Information Released **TO**:	**Dodson Pain Consultants, PA** **4600 Lake Road Ave Suite 301** **Robbinsdale, MN 55422** **E-Fax: 1-877-849-3529** **Phone: 763-588-7099**
Health Information to be Released:	Date of Service: **Last 6 Dates of Service** ____________________ Type of Visit: **ER or Office** ☑ **Clinic Record Set (Clinic Notes H/P, Progress Notes, Lab/Radiology Reports, Medications)** ☐ History and Physical ☐ Progress/Clinic Notes ☐ Laboratory Reports ☐ Medications ☐ Radiology Reports ☐ Discharge Summary ☐ Procedure Notes ☑ **Other: Historical if no Recent Radiology Imaging Reports available -Any date of service For Cervical, Thoracic, Lumbar Spine or Knee imaging. No CD-ROM disc. Report Only** All information regarding Alcohol/Drug Use or Abuse, Mental Health, and /or HIV or AIDS will be released unless you tell us not to by initialing below: ________Do not release alcohol/drug use or abuse records ________Do not release mental health records ________Do not release HIV/AIDS records.
Type of Release:	☑Hard copies ☐ Verbal Exchange
Purpose of Release	☐ Personal ☐ Attorney ☐ Insurance ☐ Disability/social security ☑ **Continued Care** Other:____
Delivery Method:	☑**MAIL** ☑]**FAX** ☐PICK-UP BY PATIENT With ID
Authorization / Revocation	This authorization will terminate in one year unless otherwise specified: _______________________ I understand that I may stop this release at any time by writing to DPC Health Information Management department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when health information is released, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that DPC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X____ Date: ___________ Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Relationship to patient (if not patient):____ *Note: An adult patient (18 years or older) must authorize the release of their own information, unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.* A photocopy of this completed and signed authorization is as valid as the original
Staff Use Only	Info Released By:_____________________________________ Date:___________________ Form of ID: ☐DL ☐State ID ☐ID Passport ☐Other: _________________________________

Health Information Management- Release of Information Dodson Pain Consultants, PA
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