Minnesota
Allergy & Asthma
Clinic, PA

PATIENT AUTHORIZATION FORM

(PLEASE LIST ANY DOCTORS AND / OR FAMILY MEMBERS WHO YOU WOULD WANT TO HAVE ACCESS TO YOUR MEDICAL RECORDS)

I hereby authorize Minnesota Allergy & Asthma Clinic, PA to disclose my PHI (protected health information to the following person(s) or entity(s) :

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

I understand that I may revoke this authorization in writing by contacting your office at your Clinic's address below, attention Privacy Officer.

Patient Name: _____Signature:_____

Relationship to patient:_____ Date: _____

THIS DOCUMENT WILL REMAIN IN EFFECT FOR ONE YEAR

Minnesota Allergy & Asthma Clinic, PA
Attn: Privacy Officer
350 W Burnsville Parkway, Suite 200
Burnsville, MN 55337