

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

Name:	Patient Information:		
Phone:		Name:Maiden Name/Alias:  Date of Birth:/	
Person/Organization:     Person/Organization:     Person/Organization:     Person/Organization:     Person/Organization:       Person/Organization:			
Person/Organization:     Person/Organization:     Person/Organization:     Person/Organization:     Person/Organization:       Person/Organization:		Phone:	
Health   Information   Released TO:   Plymouth, MN 55441   Phone: 763-588-7099   Phone: 763-588-70	Information Released	Person/Organization:	
DPC Medical 28 Nathan LN N.   E-Fax: 1-877-849-3529   Plymouth, MN 55441   Phone: 763-588-7099		City/State/Zip:	
Information Released TO:  Plymouth, MN 55441  Phone: 763-588-7099  Phone: 763-588-7099  Date of Service: Last 2 Dates of Service Relating to		Fax:	Phone:
Health Information be Released:    Date of Service: Last 2 Dates of Service Relating to			
Information to be Released:  ✓ Complete Diagnosis/Active Problem List ✓ Most Recent Radiology Reports  NO CD-ROM DISC! REPORT ONLY!  Purpose of Release  Delivery Method: ✓ FAX  Authorization /Revocation  This authorization will terminate in one year unless otherwise specified:		28 Nathan LN N. Plymouth, MN 55441	E-Fax: 1-877-849-3529 Phone: 763-588-7099
Most Recent Radiology Reports	Information to be	☑ Date of Service: Last 2 Dates of Service Relating to	
Purpose of Release  Delivery Method:  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 redisclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. Iunderstand that DPC will not condition treatment, payment, enrollment, or eligibility for benefits on whether Isonthee 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  X Date: Signature (if signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)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.		✓ Complete Diagnosis/Active Problem List	
Purpose of Release  Delivery Method:  FAX  Authorization /Revocation  This authorization will terminate in one year unless otherwise specified:		✓ Most Recent Radiology Reports	
Delivery Method:    FAX		NO CD-ROM DISC! REPORT ONLY!	
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Phone 763-588-7000 F-Fey 1-877-840-3520		 h Information Management- Releas	e of Information DPC Medical