SOUTHSIDE
Your Community Health Services

DENTAL CLINIC
4243 4th Ave S., Minneapolis, MN 55409

Authorization for Disclosure of Health Information
Patient Request for Access to Patient Health Information

Patient Information

Patient Name (Last, First, Middle)			Account Number	
Street Address		City	State	Zip
Date Of Birth	Social Security Number	Day Phone	Evening Phone	

Information Released To or From			Information Released To / Exchanged With		
Facility Name SCHS Dental Clinic			Facility Name		
E-mail Address xray.dental@southsidechs.org			E-mail Address		
Street Address 4243 4th Ave South			Street Address		
City Minneapolis	State MN	Zip 55409	City	State	Zip
Dental Records 612-821-2813	Fax 612-821-2818		Phone	Fax	

Please Indicate The Information To Be Disclosed

- ❑ Laboratory Report(S)
- ❑ Clinical Notes
- ❑ Radiology Films/X-Rays/Report
- ❑ History And Physical
- ❑ Operative Report
- ❑ Prenatal Records
- ❑ Billing Records/Statement (Date):
- ❑ Pathology Report
- ❑ Other _____

This Information Is To Be Released For The Purpose Of

- ❑ Patient Access
- ❑ Insurance Application
- ❑ Social Security Disability
- ❑ Litigation
- ❑ Continuing Care
- ❑ Social Security Appeal
- ❑ Transfer Of Care
- ❑ Other _____

Note: a fee may be charged in accordance with MN statute 144.335 and federal rule 164.524

I understand that i may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your notice of privacy practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. A photocopy/fax of this authorization will be treated in the same manner as an original.

Further, I realize that SCHS cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore SCHS is released from any and all liability resulting from redisclosure.

Patient/Legal Representative signature	Date	Authority to act on Behalf of Patient (attach document)	Information Released by	Date