AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION	
Patient Name:	Date of Birth:
Address:	Telephone Number:
	Social Security Number:

I request and authorize Wellstone Health Partners to disclose all protected information for the purpose of review and evaluation as selected below:

The following information is requested and may be released:		
□ **All Medical Records**	□ Medication Records	□ Radiology Reports
□ Pharmacy/Prescription Records	□ Billing Redords	□ Immunization Records
□ Lab Reports	□ Other: _____	

Please release records from the following dates: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or (HIV), and alcohol and drug abuse. I authorized the release and disclosure of this type of information. _____ (initial)

Release the Information To:	**From:**
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:

The purpose and the use and/or disclosure is: _____
I understand that:

a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b) The information released in response to this authorization may be re-disclosed to other parties.
c) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION	
_____ Signature of Patient Legally/Legally Authorized Representative to Patient	_____ Date
_____ Printed Name and Relationship of Legally Authorized Representative to Patient	_____ Date
_____ Witness Signature	_____ Date