UNIVERSITY OF MINNESOTA

Twin Cities Campus | *Cleft Palate - Craniofacial Clinics*

School of Dentistry
6-296 Moos Health Science Tower
515 Delaware Street Southeast
Minneapolis, MN 55455-0348

Phone: 612-625-5945
Fax: 612-624-0777

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the release of my health information

FROM:	**TO:**
Name: ______________________________ (Person or Clinic)	Name: University of Minnesota Cleft &Craniofacial Clinic (Person or Clinic)
Address: ______________________________	Address: 515 Delaware Street SE 6-296 Moos Tower
City: ______________ State: ____ Zip: ______	City: Minneapolis State: MN Zip: 55455

I specifically authorize the release of the following information: ** ______________________________

____
(what illness or condition)

Reason for release of information: ______________________________
(continuing care, completing a form etc.)

☐ **LETTER/FORM COMPLETION** ☐ **VERBAL COMMUNICATION** ☐ **PRINTED COPIES OF RECORDS**

**** ALL RECORDS PERTAINING TO PSYCHOTHERAPY/MENTAL HEALTH CLINIC TREATMENT WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING**

I specifically authorize the disclosure of printed copies of the following records:

☐ Psychotherapy/Mental Health Clinic ______________________________ (Signature) ______________ (Date)

PATIENT IDENTIFYING INFORMATION

Birth date: ________/______/_______

Name (Please Print) ______________________________ Maiden/former/alias: ______________________

Medical Record #: ______________________

Address: ____

Telephone – Home (______)______________________ Work: (_________)______________________

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year form the date of my signature.
- I understand that once information is released pursuant to this authorization, the Cleft Palate Craniofacial Clinic cannot prevent the re-disclosure of the information to another third party.
- Your treatment will not be conditioned on your signing this authorization except for research-related treatment.
- You are entitled to a copy of this *Authorization for the Release of Health Information*.
- The Cleft Palate Craniofacial Clinic **does not** release information from other providers.

______________________________	______________________________	______________
Signature of Patient/Authorized Person *(if authorized person signing, also print name)*	Authorized Person's authority to sign *(Parent, guardian, power of attorney, etc)*	Date

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐Other ______________________

PLEASE CHECK ONE: ☐ I or ______________________ (valid picture ID required) will pick up the information at the CPC-CFC Clinic on ______/______/______. (Allow at lease one week unless other arrangements are made with Correspondence at **(612) 625-5945 or FAX (612)-624-0777.**

☐ Mail the information to the address at the top of the page.

☐FAX the information to: ______________________________

Charge/Fee: ______