evergreen
primary care

**MEDICAL RECORDS RELEASE AUTHORIZATION**

**Patient Information:**
Last Name: _____ First Name: _____ Middle Initial: ___
Date of Birth (mm/dd/yy): _____/_____/_____
Previous Names: _____
Home Address: _____
City: _____ State: _____ Zip code: _____

**I am requesting that health information be released from:**

_____

**I am requesting that my health information be sent to:**

Evergreen Primary Care
Drs. Anita MacDonald, Leslie Surbeck and Shary Vang
570 Asbury Street, Suite 208, St Paul MN 55104
Phone 651-376-3484
**PLEASE FAX Records to: 651-349-0005**

**Information to be released (indicate only the information you are authorizing to be released)**

☐ Complete medical record from date _____ to present, including:
**Last annual exam, last colonoscopy, last PAP smear, last mammogram, labs from past 2 years** (if applicable)

And/Or release specific portions of your health information as indicated below:

_____
_____

The following information requires special consent by law, even if you indicate “complete medical record” you must specifically request the following information to be released

☐ Chemical Dependency program notes
☐ Psychotherapy notes (must be a separate request)

Reason(s) for releasing information

☐ Transfer of care
☐ Other _____

I understand that my physician at Evergreen Primary Care will not condition treatment on whether I sign this consent form

This consent will end one year from the date the form is signed

Patient/Legal Representative signature _____Date:_____
Representative’s relationship to patient _____