Children's Respiratory & Critical Care Specialists PA

Pediatric Pulmonary
(612) 813-3300 | Minneapolis
(651) 220-7000 | St. Paul

Pediatric Intensive Care
Children's Hospitals & Clinics of Minnesota in Minneapolis & St. Paul
Gillette Children's Specialty Healthcare
North Memorial Medical Center

Appointments Also Available in:
Minnetonka - St. Cloud
Outside Metro Area (888) 242-3327
crccs.com

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	NAME:_____ DATE OF BIRTH: _____ Address:_____ Phone:_____ City: State: Zip:
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?)	Name/Clinic Name: **Children's Respiratory & Critical Care Specialists, P.A.** Address: **2530 Chicago Ave S, Suite #400** Phone: **(612) 813-3300** Fax: **(612) 813-3349** City: **Minneapolis** State: **MN** Zip: **55404**
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	Name/Clinic Name: Crescent Cove Medical Records Attention To: care coordinator Address: 4201 58th Ave N Phone: 952.426.4711x7 Fax: 651.300.1350 City: Brooklyn Center State: MN Zip: 55429
Information to be Released (***What*** do you want sent or released? Check all boxes that apply.)	Routine Record Sets: ☑ Clinic (office visit, ~~lab, radiology – CXRs (actual CD/film please), medicines, immunizations~~) ☐ Billing Records ☐ Any and all records (includes ALL types of records listed below) Only record types checked below: ☑ Operative Reports ☑ Correspondence ☑ Hospital Visits/Summaries ☑ Special Diagnostic Reports ☑ Home Care orders ☑ Pulmonary Function Tests Optional limits – Disclose only records related to the following: Date(s) of service:_____ injury or illness: _____
Release Instructions (***How*** and ***When*** do you want the information?)	Date information is needed:_____ Release Method (check one): ☐ Paper/Mail (x) Fax – Please list fax number(s): **(612) 813-3349**
Purpose of release (***Why*** is it needed?)	☑ Continuing care ☐ Litigation/legal ☐ Transfer of care ☐ Social security appeal ☐ Insurance application ☐ Social security disability determination ☐ Insurance payment/claim ☐ Personal use or review

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Children's Respiratory & Critical Care Specialists, P.A. ('CRCCS') Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- CRCCS will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- CRCCS records may include records that it received from other organizations. If these records have been used by CRCCS and filed in the record CRCCS maintains about you, these records may be released with your CRCCS records.
- CRCCS cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release CRCCS from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above

_____ _____ _____
Signature Relationship to Patient Date

Click to Submit

**NOTE: By submitting this document to Children's Respiratory & Critical Care Specialists, you are providing implied consent that you understand the risks of sending personal health information in a non-secure email format.*