Bluestone Physician Services

Authorization for Release of Health Information

Patient Information: *Please use full legal name*

Last Name:_____ First Name:_____ M.I. ___ Date of Birth:__/__/_____

Release Information From:

Clinic Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Release Information To:

MINNESOTA

☐ Bluestone Physician Services
270 Main Street N, Suite 300
Stillwater, MN 55082
Phone: 651-342-1039
FAX: 651-342-1428

WISCONSIN

☐ Bluestone Physician Services
888 Thackeray Trail, Suite 103
Oconomowoc, WI 53066
Phone: 262-354-3744
FAX: 1-888-972-8297

FLORIDA

☐ Bluestone Physician Services
300 South Hyde Park Ave, Suite 210
Tampa, FL 33606
Phone: 813-259-1013
Fax: 813-254-0396

Information To Be Released:

Indicate ONLY the information that you are authorizing to be released.

☐ **ALL HEALTH INFORMATION** ☐ CD of Images ☐ Specific dates/years of treatment _____

OR Release Indicated Records only:

☐ History Form ☐ Doctor Notes ☐ Laboratory Reports ☐ Operative Reports
☐ Radiology Reports ☐ Therapy Notes ☐ Injection Notes ☐ EMG Reports
☐ Radiology Images ☐ Billing Statements ☐ Other Information/Instructions_____

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

Chemical dependency program: Yes____No____ Psychotherapy notes: Yes____ No____

I hereby authorize the release of my individually identifiable health information as described. I understand that this authorization to release health information is voluntary. I understand that if the organization authorized to receive this information is not a health plan or healthcare provider, the release of my health information may no longer be protected by federal privacy regulations as described in the Notice of Privacy Practices of Bluestone Physician Services.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone. I understand that if I revoke this authorization it will not have any effect on any actions taken by the Bluestone Physician Services before it received my revocation.

_____ _____

Patient or Legal Representative Signature **Date**

_____

Legal Representative Printed Name

_____

Authority to sign for patient (i.e. Health Care Directive, Medical POA –*must include documentation*)