



Clary Document Management, Inc.
4730 Quebec Avenue North
Minneapolis, MN 55428

Phone: 763.548.1320 | Fax: 763.548.1325 | chartcontrol@clarydm.com | www.clarydm.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____

Address: _____

Day Phone: _____

Email: _____

I request that all medical records of the patient
named above to be released from:

Send all medical records to:
Me at same address/email as above
My new healthcare provider below

Vein Clinic PA
7810 Terrey Pine Court
Eden Prairie, MN 55347

Name: _____

Address: _____

Reason for Release of Information:

Email: _____

Fax : _____

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws.

I understand should I request copies be sent to me I will be charged a \$20 fee to reproduce the records and reports, there is no fee if records are forwarded to another healthcare provider.

Patient Signature _____

Date _____

Patient Authorized Representative: _____

Date _____

Authority to Represent Patient: _____