TRINITY *Integrative* MEDICINE, P.A.

DR. BERNARDA ZENKER, M.D.

5123 W. 98TH, #1272
BLOOMINGTON, MN 55437
TEL 952.465.3883 • FAX 952.465.3885

C

PATIENT DATA				
	Patient Name (Last, First, M.I.)			Date of Birth
	Street Address			Home Phone
	City	State	ZIP Code	Other Phone (Circle Work or Cell)

Information
Information

Released **FROM**:
Released **TO**:

Name of Clinic		Name (Hospital, Clinic, Attorney, Insurance Company or Individual)	
Street Address		Street Address	
City	State ZIP Code	City	State ZIP Code
Phone Number	FAX	Phone Number	FAX

INFO

INFORMATION to be released: (mark all that apply)

- ❑ All Medical Records
- ❑ Records about Specific Condition: _____
- ❑ Other (please specify): _____
- ❑ Medications
- ❑ Progress Notes
- ❑ History and Physical
- ❑ Laboratory Report(s)
- ❑ Hospital Records

DATES

DATES of information to be released:

- ❑ Specific dates of service: _____
- ❑ Other (please specify): _____
- ❑ All Clinic Records
- ❑ Last 2 years
- ❑ Last 1 year
- ❑ Last 6 months

REASON

REASON for release of information:

- ❑ Consult with Family Member (named above)
- ❑ Other (please specify): _____
- ❑ Transfer of Medical Care
- ❑ Legal/Litigation
- ❑ Personal Use
- ❑ Referral for Medical Care
- ❑ Facilitate Treatment
- ❑ Insurance Claim

Authorization Expiration Date or Event: _____ (If left blank, authorization will expire one year from date of signature.)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. **Trinity Integrative Medicine** will not refuse or restrict my treatment if I choose not to sign the Authorization. A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original. Further, I realize that **Trinity Integrative Medicine** cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections: therefore, **Trinity Integrative Medicine** is released from any and all liability resulting from redisclosure.

Signature of Patient _____ Date _____

Signature of Parent/Legal Representative _____ (Relationship) _____ Date _____