AUTHORIZATION TO TRANSFER MEDICAL INFORMATION TO NEW KINGDOM HEALTHCARE

FROM OTHER FACILITY (Please provide facility information in which you want records transferred below):

NAME:____

ADDRESS:____

CITY:______________________ **STATE**______________ **ZIP CODE**____________

TELEPHONE:______________________ **FAX#**______________________

For the purpose of continuing medical care, I hereby authorize and request you to furnish the following information to:

New Kingdom Healthcare
6452 City West Parkway
Eden Prairie, MN 55344
Phone:952-999-0333/Fax:952-300-2558

Please Release Information for:

Patient Name ______________________________ **Date of Birth**______________

Patient's Address____

Patient's Primary Telephone______________________ **E-mail**______________________

Information Requested: ***Date Range*** ______________ to ______________

- ✓ Office Visit Notes
- ✓ Immunization Records
- ✓ Problem List/Health Summary
- ✓ Eye Records
- ✓ Laboratory Reports
- ✓ Imaging/Radiology Reports
- ✓ Hospital/Inpatient Notes
- [ ] Other (Please Specify):______________________
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I understand per federal law that the following information **<u>will not be released to New Kingdom Healthcare unless signed below</u>**. Therefore, I specifically authorize the release of information relating to:

[ ] Substance Abuse (alcohol/drug abuse)
[ ] HIV-Related Information (AIDS related testing)
[ ] Mental Health (includes psychological testing)
[ ] Developmental Disabilities

____
Signature of Patient/Parent/Guardian/Legal Representative **Relationship to Patient** **Today's Date**

I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect or copy the information to be used or disclosed. I understand that written notification is necessary to cancel this authorization. I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. This authorization is effective for one year from the date signed unless otherwise indicated.

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Signature of Patient/Parent/Guardian/Legal Representative ***Relationship to Patient*** ***Today's Date***

Updated 8-8-16