CHILDREN'S RESPIRATORY & CRITICAL CARE SPECIALISTS,P.A.

Steven Baisch, MD
Keith Cavanaugh, MD
Mark Eikenberry, MD
John Fugate, MD
Kendra Gram, MD
Steven Haun, MD
Kristine Hendrickson, MD
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Cynthia Brady, DNP
Julie Herda, CPNP

Pediatric Intensive Care

Children's Hospitals and Clinics of Minnesota
• Minneapolis
• St. Paul

Gillette Children's Specialty Healthcare

North Memorial Medical Center

Pediatric Pulmonary

2530 Chicago Ave S
Suite 400
Minneapolis, MN 55404
(612) 813-3300
Fax: (612) 813-3349

310 North Smith Ave
Suite 460
St. Paul, MN 55102
(651) 220-7000
Fax: (651) 220-7025

Appointments Also Available in:

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(888) 242-3327

www.crccs.com

AUTHORIZATION FOR RELEASE OF INFORMATION/DISCLOSURE
PATIENT OVER 18 YEARS OF AGE

I request and authorize **CHILDREN'S RESPIRATORY & CRITICAL CARE SPECIALISTS, P.A.** to release photocopies and/or verbal communications for medical records of:

This information will be used for:
- ☐ Pulmonary Evaluation
- ☒ Continuation of care
- ☐ Insurance Claim
- ☐ Litigation
- ☐ Other:_____

The specific information authorized to be released is:

☒ Entire medical record (Includes everything listed below)	☐ Laboratory Reports	☐ Hospital Summaries/Visits
☐ Narratives	☐ Radiology Reports	☐ Operative Reports
☐ Consults	☐ Correspondence	☐ Special Diagnostics
☐ PFTs	☐ Homecare Orders	☐ Other
	☐ Misc.	

For the dates of service: _____ALL_____

I authorize:
_____Children's Respiratory & Critical Care Specialists, P.A._____

To release/disclose information to:

☐ Mom's name: _____

☐ Dad's name: _____

☐ Other name: _____

I understand that:

- The designated record set may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, child abuse, or alcohol/drug abuse treatment.
- This Authorization for Disclosure will expire one year from the date of my signature.
- This authorization for disclosure may be revoked at anytime if done in writing and presented to John Stamm, Administrator.
- Revocation will not apply to information already disclosed with this authorization for disclosure and/or information disclosed for purposes of treatment, payment and health care operations.
- Refusal to sign this Authorization for Disclosure will not affect treatment.
- You may inspect or copy the information for use or disclosure with this Authorization for Disclosure.
- Authorized disclosure of information may be subject to unauthorized re-disclosure.

Signature _____ Date _____
Patient or Legal Guardian

Relationship to Patient: Self ( ) Mother ( ) Father ( ) Foster parent ( ) Other ( )

If you have any questions, please contact our office at (612) 813-3300. Thank you.