Lifesprk Health
Whole Person Senior Care
Primary Care

Authorization for Release of Health Information

Member Name: *Please use full legal name*

Last Name: _____ First Name: _____ MI: _____ DOB: _____

***Release Information From (required):**

Clinic Name: _____

Phone: _____

Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

*Release Information To:

❑ Lifesprk Health
Attn: Cathy Lauring, NP
5320 W 23rd Street
Suite 130
St. Louis Park, MN 55416

Fax: 844-593-1082
Phone: 952-345-3213

Information To Be Released (required): *Indicate ONLY the information that you are authorizing to be released.*

❑ **ALL HEALTH INFORMATION** ❑ Specific dates/years of treatment: _____

OR *Release indicated records only:*

❑ History/Physical
❑ Medication
❑ Billing records
❑ Doctor/provider visit notes
❑ ED/ER reports
❑ Radiology reports
❑ Procedure reports
❑ Laboratory reports
❑ Hospital records
❑ Therapy notes
❑ Operative reports
❑ Discharge summary
❑ Radiology images
❑ Immunizations
❑ Other information/instructions: _____

The following information requires special consent by law. Even if you indiciate 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 described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

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 Lifesprk Health. I understand that if I revoke this authorization it will not have any effect on any actions take by Lifesprk Health before receiving my revocation. This release covers past, present, and future encounters/visits unless I write in specific treatment dates here: ____ to _____ . This consent will expire one year from the date it is signed unless I write in a specific expiration date here:

_____ _____

Patient or Legal Representative Signature Date

_____

Legal representative printed name and authority to sign for member
(i.e. Health Care Directive, Medical POA - *please include documentation*)