AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

www.MNORTHOSURGERY.com

FAX 763-786-0471
PHONE 763-786-0461

PLEASE PRINT OR TYPE

PATIENT NAME ____ BIRTH DATE ________________

STREET____

CITY____ STATE ________ ZIP CODE ____________

TELEPHONE: HOME ____________________ CELL _________________________

I hereby request and authorize:

MN ORTHOPAEDIC SURGERY CENTER
8290 UNIVERSITY AVE NE, SUITE 100
FRIDLEY, MN 55432

T0 RELEASE COPIES OF MY RECORDS TO:

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□ Mail to Patient

□ Patient will pick up

□ Fax to _____________________

□ Other _____________________

TYPE OF INFORMATION TO BE DISCLOSED:

□ Operative Report □ Anesthesia Record □ Nursing Notes □ X-rays/arthroscopy photos

□ Implant/Prosthetic Record □ Other ____

THE INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE:

□ Insurance □ Legal (must be requested by attorney) □ Medical Care □ Personal Use

APPROXIMATE DATE OF TREATMENT: ___________________________________

I understand that I may revoke this consent at any time, and that this authorization will automatically expire 180 days from the date of my signature.

Patient's signature ____ Date ______________

(signature and date must be in ink)

Spouse, Parent, or Guardian
authorizing release ____ Date ______________

Medical Records Released by: ____ Date ______________