AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
PLEASE PRINT OR TYPE

PATIENT NAME _____BIRTH DATE_____

STREET_____

CITY_____STATE_____ZIP CODE_____

TELEPHONE:
HOME_____WORK_____

I hereby request and authorize:

Facility name and complete address

_____
Date

To release copies of my medical records to:

MN ORTHOPAEDIC SURGERY CENTER 8290 UNIVERSITY AVE NE, SUITE 100 FRIDLEY, MN 55432
Facility name and complete address

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

TYPE OF INFORMATION TO BE DISCLOSED:

Records: HISTORY & PHYSICAL EXAM. EKG, LABS, CARDIAC TEST RECORDS IF INDICATED.

Approximate date of treatment:_____

The information is needed for the following purpose:
❑ Medical Care

Other: MEDICAL RECORDS TO EVALUATE FOR CLEARANCE IN AMBULATORY SURGERY CENTER

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. I understand that once information is released pursuant to this authorization, MOSC cannot prevent the disclosure of the information to another third party. MOSC will not condition treatment on my signing this authorization. I understand there may be a retrieval and copy charge associated with the release.

Patient's
signature_____Date_____
(signature and date must be in ink)

Spouse, Parent or Guardian
authorizing release_____Date_____

If someone other than the patient is signing, state the relationship to the patient and reason the patient cannot sign:

_____

Medical Records Released by _____Date_____