

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____
Address: _____
Phone: _____
Date of Birth: _____ SSN: _____

I authorize the custodian of records of or other person/entity (specifically describe) Minnesota Spine Institute **OR** Other: _____ to disclose the following information* (check all applicable):

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Abstract/Summary |
| <input type="checkbox"/> Laboratory/Pathology records | <input type="checkbox"/> Pharmacy/Prescription records |
| <input type="checkbox"/> X-ray/Radiology records | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Billing Records | |

*NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following dates: _____

Please make a selection below.

___ Please mail records to me. My address for mailing is: _____

___ Please send records listed above to:

Minnesota Spine Institute

PO Box 430

Isanti, MN 55040

Phone: 612-670-4971 Fax: 612-440-2178

This authorization shall expire no later than: ___/___/_____ or upon the following event _____ (whichever is sooner), and may not be valid greater than one year from date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of Patient (Or Patient's Representative)

Date

Printed Name of Patient Representative

Representative's Authority to Sign (Parent, Guardian, POA)