Patient Authorization for Release of Health Information

Minnesota Occupational Health

INTEGRATED, COMPREHENSIVE OCCUPATIONAL HEALTH SERVICES

Con la firma de este formulario, usted está dando el consentimiento explicado en este formulario.
Un intérprete de español está disponible a su solicitud.

1. PATIENT INFORMATION

First name: _____ **Middle name:** _____ **Last name:** _____

Date of birth: ____/ ____ / ____ ☐ **Male** ☐ **Female** **Previous name(s):** _____

Address: _____ City _____ State _____ ZIP _____

Today's date: ____/ ____ / ____ (Month / Day / Year) **Daytime phone:** (____) ____ – _____ **Email address:** _____

2. I AM REQUESTING HEALTH INFORMATION BE SENT ☐ TO / ☒ FROM: ☐ SEND TO PATIENT

Organization/clinic name: Twin Cities Occupational Health & Rehab Attention: Penny Seeds, RN

Address: 2520 Pilot Knob Road, Ste 250 Mendota Heights (City) MN (State) 55120 (ZIP)

Fax: (____) ____ – _____ **Phone:** (____) ____ – _____

Date information needed: 12 / 28 / 2016 (Month / Day / Year) (Please allow a minimum of 7-10 business days for processing)

3. I AM AUTHORIZING THAT HEALTH INFORMATION BE RELEASED ☒ TO / ☐ FROM:

MINNESOTA OCCUPATIONAL HEALTH ☐ SUMMIT ORTHOPEDICS PROVIDERS / LOCATIONS

☒	EAGAN LOCATION:	1400 Corporate Center Curve, Suite 200, Eagan, MN 55121	Phone: 651-968-5300 Fax: 651-686-4026
☐	ST. PAUL LOCATION:	1661 St. Anthony Ave., 2nd Floor, St. Paul, MN 55104	Phone: 651-968-5300 Fax: 651-646-0205
☐	BLAINE LOCATION:	10230 Baltimore St., #300, Blaine, MN 55449	Phone: 651-968-5300 Fax: 651-730-3516

4. INFORMATION TO BE RELEASED

Indicate ONLY the information that you are authorizing to be released.

☐ CD of images	☐ Specific dates of treatment _____	
☒ History form	☒ Doctor notes	☐ Laboratory reports
☐ Radiology reports	☐ Therapy notes	☐ Operative reports
☐ Injection notes	☐ Billing statements	☐ Electromyography (EMG) report

☐ Other information or instructions _____

CONTINUED ON NEXT PAGE

THE FOLLOWING INFORMATION REQUIRES SPECIAL CONSENT BY LAW.

You must specifically request that the following information be released and it cannot be combined with any other request.

☐ Chemical Dependency Program ☐ Mental Health / Psychotherapy Notes

5. Release method/format requested: ☒ Paper ☐ Fax ☐ CD (images only)

6. Reasons for releasing information: ☐ Patient's request ☐ Review patient's current care ☐ Treatment/continuity of care

☐ Sharing testimonial for Summit Orthopedics' marketing purposes

☒ Other Transfer of medical surveillance records

I understand that by signing this form, I am requesting that the health information specified be sent to me or the third party listed above. I understand that I may revoke this request at any time in writing to Summit Orthopedics. The revocation will not apply to records already released. Summit Orthopedics will not condition treatment on whether I sign this authorization. I understand that the information can be re-disclosed by the third party listed above and once received, it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

This consent will end one year from the date the form is signed (but consents for testimonials will expire as soon as administratively practicable after your request).

Patient's signature OR authorized person's signature: _____

Print name: _____

Date: ____/ ____ / ____
Month Day Year

Authorized person's authority to sign (proof required):

☐ Patient is a minor ☐ Legal Representative ☐ Power of Attorney

☐ Other _____

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[1] Summit Orthopedics, Ltd., includes its clinics, surgery centers, diagnostic imaging centers, recovery suites, bracing and orthotics, Minnesota Occupational Health and the Woodbury Ambulatory Surgery Center, LLC.

Records released by: _____ _____

Date: ____/ ____ / ____ MR# _____ DR# _____
Month Day Year