MINNEAPOLIS ORTHOPAEDICS
Advanced skills and experience for the results you deserve

825 S. 8th St., Suite 550
Minneapolis, MN 55404
Phone: 612-333-5000 Fax: 612-333-6922

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT	Patient name (print)			Date of Birth
	Street Address			
	City	State	Zip	Phone #
Health Information Released FROM: (***Who*** has the information you want released?)	Name: MINNEAPOLIS ORTHOPAEDICS			
	Street Address: 825 S. 8TH ST., SUITE 550			
	City: MINNEAPOLIS	State: MN	Zip: 55404	Fax #: 612-333-6922
Health Information Released TO: (***Where*** do you want the information sent?)	Name			
	Street Address			
	City	State	Zip	Fax #

Health Information to be Released: (***What*** records do you want released?)	For condition or dates of treatment:_____ € Complete medical record (with x-ray/MRI images) € Complete medical record (without x-ray/MRI images) **OR** to only release specific portions of your health information, indicate the categories to be released: € Office notes € MRI reports € X-ray images (CD) € Operative reports € EMG reports € MRI images (CD) € Physical therapy notes € Other_____
Purpose of Release: (***Why*** is it needed?)	€ Personal use € Legal* € Other _____ € Continued care € Insurance* *There may be a charge/fee for copies of records under MN Statute 144.292.
Authorization/Revocation	By signing this authorization I understand the following: This form expires one year from the dated I sign it unless otherwise indicated here: _____. I am requesting that the health information marked above be released to the person, clinic or organization above. I may revoke this consent at any time in writing to Minneapolis Orthopaedics. If I do not sign this form, I will still be treated. Upon release, this health information is no longer protected by Minneapolis Orthopaedics and may be released to a third party. A faxed/copy of this authorization is as valid as the original. **Signature** _____ **Date:** ____/_____/____ Or legally authorized representatives signature_____ Representative's relationship to patient € Parent € Guardian € Other _____