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) _____
Other: _____ **to disclose the following information* (check all applicable):**

- ◯ All records
- ◯ Abstract/Summary
- ◯ Laboratory/Pathology records
- ◯ Pharmacy/Prescription records
- ◯ X-ray/Radiology records
- ◯ Other _____
- ◯ 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 one of the following locations: (please circle)

Minnesota Spine Institute
2780 Snelling Ave N, Suite 310
Roseville, MN 55113

OR: _____
_____
_____

Phone: 612-670-4971 Fax: 612-404-2580

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)