



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION:	Patient Full Name (print):	DOB:
	Address (City, State, and Zip Code):	
	Phone Number:	Email Address:

HEALTH INFORMATION RELEASED FROM:	<input type="checkbox"/> Summit Orthopedics, LTD. 710 Commerce Dr. #200, Woodbury, MN 55125 -OR-	Phone: 651-968-5125 Fax: 651-968-5907
	<input type="checkbox"/> Name of Organization/Clinic:	Attn:
	Address (City, State, and Zip Code):	
	Phone Number:	Fax Number:

HEALTH INFORMATION RELEASED TO:	Name of Organization/Clinic:	Attn:
	Address (City, State, and Zip Code):	
	Phone Number:	Fax Number:

HEALTH INFORMATION TO BE RELEASED:	<input type="checkbox"/> Specific Date/Year of Treatment _____				
	<input type="checkbox"/> CD of Images	<input type="checkbox"/> Doctor Notes	<input type="checkbox"/> Therapy Notes	<input type="checkbox"/> Operative Report	
	<input type="checkbox"/> Injection Notes	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> EMG Report	<input type="checkbox"/> Billing Statement
	<input type="checkbox"/> Other _____				
The Following Requires Special Consent by Law and must specifically be requested in order for it to be released:					
<input type="checkbox"/> Chemical Dependence Program			<input type="checkbox"/> Psychotherapy Notes		
DELIVERY METHOD:	<input type="checkbox"/> Paper/Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> CD of images only (Mail)		
PURPOSE FOR RELEASE:	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Continued Care	<input type="checkbox"/> Marketing (Sharing testimonial for Summit Orthopedics)		
<input type="checkbox"/> Other _____					

I understand that by signing this form, I am requesting that the health information specified be sent to 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).

_____ Print Name	_____ Signature	_____ Date
Authorized Person's authority to sign (proof required): <input type="checkbox"/> Patient is a Minor <input type="checkbox"/> Power of Attorney or Legal Representative <input type="checkbox"/> Other _____		

Summit Orthopedics, Ltd. includes its clinics, surgery centers, diagnostic imaging centers, recovery suites, bracing and orthotics, the components of Minnesota Occupational Health that are subject to HIPAA, and the Woodbury Ambulatory Surgery Center, LLC.

Released By: _____ Date: _____ MRN: _____ Physician: _____