



**AUTHORIZATION FOR  
RELEASE OF  
INFORMATION**

MR # \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone Number: \_\_\_\_\_

This will authorize \_\_\_\_\_  
(Name/Dept/Address)

to release information to: \_\_\_\_\_  
(Name/Title of Person/Organization)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

Information to be released includes records from the following dates: \_\_\_\_\_

Information to be released:

- |                                      |                                |
|--------------------------------------|--------------------------------|
| _____ Cardiac Test Results           | _____ Operative Reports        |
| _____ Consultation Reports           | _____ Pathology Reports        |
| _____ Discharge Summary              | _____ Physician Orders         |
| _____ EKG Reports                    | _____ Physician Progress Notes |
| _____ Emergency Department Reports   | _____ Radiology Films          |
| _____ History & Physical Examination | _____ Radiology Reports        |
| _____ Laboratory Reports: _____      | _____ Other (specify): _____   |
| _____ Nurses Notes                   |                                |

**Reports released may include information about mental status/drug/alcohol and HIV testing results. If there is specific information that you do not want released, please write here:**

\_\_\_\_\_

The information is needed for the following purpose: \_\_\_\_\_

Information to be released via:     Mail     Pick-up     FAX     Courier     Review Only

This authorization will expire upon the earliest of the following dates: 1) twelve months following date of signature on this form, 2) the date the stated purpose is fulfilled, 3) the date I write here \_\_\_\_\_, 4) the date that I revoke this authorization.

I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that Minneapolis Vein Center has relied on the authorization.

I understand that I may be charged a fee for the costs of copying records or for preparing a summary or explanation of records, subject to state and federal law.

A photocopy or facsimile of this authorization shall be treated as valid as the original.

I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

Date: \_\_\_\_\_  
Must be filled in

(If Patient's Representative, under what legal authority are you signing?)

- Parent             Guardian             Health Care Agent  
 Other (specify): \_\_\_\_\_