



651-430-3800 or 800-353-7720

Fax: 651-259-4584

FOR INTERNAL USE  
Faxed \_\_\_\_\_  
Mailed \_\_\_\_\_

### RELEASE OF INFORMATION

Incomplete request can not be processed

<b>PATIENT INFORMATION</b>	Name: _____ Date of Birth: _____ Address: _____ Day Phone# _____ City: _____ State: _____ Zip _____
<b>Clinic/Hospital/ Health Care Provider</b> (WHO has the information you want released?) Please list the specific Hospital and/or clinic.	Name: _____ Address: _____ Day Phone# _____ City: _____ State: _____ Zip _____
<b>Receiving Party</b> (Where do you want the information sent? Who may have this information?)	Name: _____ ATTN: _____ Address: _____ Day Phone# _____ City: _____ State: _____ Zip _____
<b>Information to be released</b> (What do you want sent or released? Check the appropriate box)	I authorized MSBI to discuss my care with the named entity(ies) listed above <input type="checkbox"/> Routine Record Set (indicate dates of service) _____ <input type="checkbox"/> Billing Records <input type="checkbox"/> Copies of Images/Films <input type="checkbox"/> ALL Records <input type="checkbox"/> Other Forms <b>Only Record Types checked:</b> <input type="checkbox"/> Discharge summary/note <input type="checkbox"/> Radiology <input type="checkbox"/> History and Exam Note <input type="checkbox"/> PT Notes <input type="checkbox"/> Operative Reports <input type="checkbox"/> Consultations <input type="checkbox"/> Progress/Clinical Notes <input type="checkbox"/> Laboratory <input type="checkbox"/> Injection Reports
<b>Release Instructions</b> (How and When do you want the information?)	<b>Date Information is needed:</b> _____ Copies of Images/Films* MSBI only releases images done by MSBI Release Method <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Fax _____
<b>Purpose of Release</b> (Why is it needed?)	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Disability / Social Security <input type="checkbox"/> Insurance <input type="checkbox"/> Personal Review <input type="checkbox"/> Litigation/Legal
<p>I understand that by signing this form, I am authorizing the release of health information specified to the third party named above. I may revoke this consent at any time by writing to the named organization. If I revoke this authorization, the organization will no longer disclose my information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when the health information specified is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named is a health care provider it will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form, except in the following situations: (i) if the medical information to be disclosed will result from treatment for research purposes, the provider will not provide the treatment if I am unwilling to sign this authorization form; and (ii) if the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, the provider will not provide the treatment if I am unwilling to sign this authorization form. If I choose not to sign this form and the organization named is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.</p> <p><b>This consent will end one year from the date the form is signed: (unless earlier date is indicated in writing)</b></p> <p><b>Patient's Signature:</b> _____ <b>Date:</b> ____/____/____</p> <p><b>Or Legally Authorized Representative's Signature:</b> _____ <b>Date:</b> ____/____/____</p> <p>Representative's relationship to patient (parent, guardian, etc.): _____</p> <p>1950 Northwestern Ave Suite 102 Stillwater, MN 55082 Locations throughout the Twin Cities and western Wisconsin MidwestSpineInstitute.com</p> <p style="text-align: right;"><b>ALLOW 2 WEEKS TO PROCESS REQUEST</b></p> <p style="text-align: center;"><b>Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R</b></p>	
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