Twin Cities Pain Clinic

Authorization for Release of Information

1. Patient Information

(office use only) Records Needed by _____

Name: _____ Date of Birth:_____

Maiden or other name(s):_____

2. I hereby request and authorize

Twin Cities Pain Clinic
7235 Ohms Lane
Edina, MN 55439
Phone: (952)841-2345
Fax: (952)841-2346

To:

□ Receive records from
□ Send records to

Person/Organization Name:
_____

Address or fax number:
_____

_____

3. Delivery

□ Fax □ Mail □ Pick Up (Photo ID Required) □ Other: _____

4. Purpose

□ Continuity of Care □ Insurance □ Disability □ Legal □ Personal □ Other

5. Health information to be released

□ Progress/Clinic Notes □ Lab Results □ Radiology Reports □ Physical Therapy Records

□ Injections/Procedures □ Psychotherapy notes □ Other, as listed: _____

All information regarding alcohol/drug use or abuse, mental health, and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:

____Do not release Alcohol/Drug Use or Abuse records
____Do not release Mental Health records
____Do not release HIV/AIDS records

6. Dates of treatment to be released

□ Please release records for the period of _____ to _____.
□ Please release records pertaining to specific injury or illness of _____.
□ Please release the most recent 6 months of records.
□ Please release all records.

7. Authorization/Revocation

This authorization will terminate in one year unless otherwise specified: _____.
I may revoke this authorization at any time by notifying the releasing organization in writing. It will be effective on the date notified except to the extent action has already been taken. This authorization is valid for records prior to and after the date signed. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy standards. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization. In compliance with MN Statute 144.33, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. I may receive a copy of the signed authorization upon request. A photocopy or fax of this document is valid as the original. Twin Cities Pain Clinic will not release medical records obtained from another health care provider or facility.

Patient Signature: _____ Date: _____