Twin Cities Surgery Center

Authorization for Release of Information

Please attach this sheet with the requested records!

PATIENT	Name: _____ Date of Birth: _____ Maiden OR Other Name(s): _____
HEALTH INFORMATION RELEASED FROM	☐ **TWIN CITIES SURGERY CENTER** 7211 Ohms Ln, Edina, MN 55439 Phone: (952) 204-3500 Fax: (952) 856-2644 ☐ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
HEALTH INFORMATION RELEASED TO	☐ **TWIN CITIES SURGERY CENTER** 7211 Ohms Ln, Edina, MN 55439 Phone: (952) 204-3500 Fax: (952) 856-2644 ☐ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
DELIVERY	☐ Fax ☐ Mail ☐ Pick up (photo ID required) ☐ Other: _____
PURPOSE	☐ Continuity of Care ☐ Insurance ☐ Disability ☐ Legal ☐ Personal ☐ Other
HEALTH INFORMATION TO BE RELEASED	☐ Procedure/Injection Notes ☐ Lab Results ☐ Radiology Reports ☐ 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
DATES OF TREATMENT TO BE RELEASED	☐ Please release 6 months of most recent records ☐ Please release 12 months of most recent records ☐ Please release records for the period of _____ to _____.
AUTHORIZATION/REVOCATION	This authorization will terminate in one year unless otherwise specified: _____. This signed authorization allows release of the requested records to TWIN CITIES SURGERY CENTER. Providing the information has not already been disclosed, this release may be revoked at any time by sending a request in writing to TWIN CITIES SURGERY CENTER. A photocopy of this signed authorization is as valid as the original. I understand that once the information is released, the information is subject to re-disclosure and may not be protected by the federal privacy regulation. TWIN CITIES SURGERY CENTER WILL NOT release medical records obtained from another health care provider or facility. Patient Signature: _____ Date: _____