AUTHORIZATION TO RELEASE/DISCUSS INFORMATION

PATIENT:	Name
	Previous Names
	Birthdate Phone #
	Address

I HEREBY AUTHORIZE: The Orthopaedic & Fracture Clinic, P.A.
1431 Premier Drive Fax: 507-625-5971
Mankato, MN 56001

To Release or Discuss:	Physician/Facility/Caregiver or Family Member
	Phone
	Address
	Relationship to Patient
	Limitations or Instructions

MEDICAL RECORDS REGARDING: _____

NEEDED FOR THE APPOINTMENT DATE of: ____/____/____

FOR THE PURPOSE of: _____

I authorize release of my medical records in accordance with the specifications listed above. This authorization is valid for one year from this date unless written notification is given.

AUTHORIZATION SIGNATURE_____DATE: _____

RELATIONSHIP TO PATIENT IF SIGNED BY GUARDIAN_____
(Spouses or parents of children 18 years of age or older cannot request/or sign for patient unless he/she is incapacitated or deceased.)

SIGNATURE OF WITNESS_____DATE_____

(Over)

Updated 4/16/14

If applicable, this authorization includes release of any records regarding psychiatric care, alcohol and/or drug abuse, or AIDS-related disease diagnosis unless otherwise specified in writing.

A photocopy of this authorization shall be considered as valid as the original.

I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once this information is disclosed to a third party, the information may be re-disclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.