Advanced Spine & Pain Clinics of MN®

Release of Medical Information from an Authorized Facility

First Name:	Middle Initial:	Last Name:	Maiden/Other:
Date of Birth:	Home Number:	Cell Number:	Other Contact:
Email Address:			
Street Address:		City State Zip Code:	

Please release my records:

From: Organization name: Advanced Spine & Pain Clinics of MN

Street Address:	2801 South Wayzata Blvd.	City State Zip Code:	Minneapolis, MN 55405
Phone Number:	6122077463	Fax Number:	6123154473

To: Organization Name:

Street Address:		City State Zip Code:	
Phone Number:		Fax Number:	

Records I would like to be released pertaining to my _____ pain:

- ☐ 3-6 most recent clinic notes
- ☐ Surgical Reports
- ☐ Procedure/Injection Notes
- ☐ Physical Therapy/Chiropractic
- ☐ Lab Results
- ☐ X-ray, MRI, CT, EMG

☐ Date records are needed: _____ or o **STAT: required for today's appointment.**

The Following Information requires special consent by law. This is not included with All Health Records; you must specifically request the following information for it to be released.

- ☐ Chemical Dependency program
- ☐ Psychotherapy notes
- ☐ AIDS/HIV

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that by signing this release I am not authorizing the parties in receipt of this information to further disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. However, I understand that this information may be subject to re-disclosure by the recipient and that it will no longer be protected by federal or state privacy laws. I understand that I may revoke this authorization at any time by giving written notification to the organization, but if I do, it won't have any effect on any actions that they took before they received the revocation. I understand that Advanced Spine & Pain Clinics of Minnesota will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent. If I choose not to sign this form and the organization named to have health information released to 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 which I may, therefore, be responsible for.

"This consent will end one year from the date the form is signed UNLESS an earlier date is indicated in writing"

Patient Signature: _____ Date: _____

Or Legal Authorized Representative's Signature: _____

Relationship to Patient: _____ Date: _____

EMAIL: refer<atcpaindoctor.com

Fax: 612-315-4473 or mail to: 2801 So Wayzata Blvd Minneapolis, MN 55405

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED