MINNESOTA
SPORT & SPINE REHAB

A member of Therapy Partners

AUTHORIZATION FOR THE RELEASE OF AND/OR REQUEST OF PATIENT ACCESS TO HEALTH INFORMATION

Patient Name ______________________ Previous Name(s) ______________________ Birth Date ______________

Street Address ______________________ City ______________ State ______ Zip ______

Phone Number (Home) ______________ (Cell) ______________ (Work) ______________

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
Minnesota Sport & Spine Rehabilitation **14000 Nicollet Avenue Suite 200** **Burnsville, MN 55337** **Phone: 952-892-6777** **Fax: 952-892-0792**	Name (hospital, clinic, attorney, insurance co, individual) ______________ Street Address ______________ City ______ State ______ Zip ______ Fax Number ______________

The information to be disclosed is:

___ Complete Record ___ Itemization of Charges ___ Discharge Summary ___ Medical History ___ Daily Notes
___ Other (specify) ______________________

The information is needed for the following purpose(s):

___ Insurance ___ Legal/Attorney ___ Personal ___ Disability ___ Continuity of Care
___ Other (please explain) ______________________

Date Range Requested:

_____ All _____ From ______________ to ______________

Statement of Authorization:

- I understand that I may revoke this authorization in writing at any time by notifying the healthcare facility listed above. If I do not revoke this authorization, it will be good for one year.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or obtain a copy of the health information to be disclosed.
- If the disclosed information goes to a healthcare provider or a health plan covered by federal privacy laws, it will be protected by federal laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be redisclosed.
- I do not have to sign this form, treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company.

Date __________ Signature of Patient/Legally Authorized Representative ______________________ Relationship to Patient ______________

Reason Patient Unable to Sign ______________________ Signature of Witness ______________________

Note: A fee may be charged in accordance with MN Statute 144.335 and Federal Rule 164.524

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Revised 11/14/12 (in TPI)