MRO
Minneapolis Radiation Oncology, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date Information Desired By _____

Patient Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Phone (____) _____

Release Information From: Provider/Facility Name _____

Address _____ City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

Release Information To: Name/Facility _____

Address _____ City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

Information To Be Released:

Release Format: ☐ Paper ☐ Electronic Release Method: ☐ Mail ☐ Pick Up ☐ Fax ☐ Courier

Service Dates: From _____ To _____

☐ Discharge Summary	☐ Consultation	☐ History and Physical
☐ Operative Report	☐ Progress Notes	☐ Lab Reports
☐ Radiology Films/Scans	☐ Radiology Reports	☐ Pathology Reports
☐ Complete Medical Record	☐ Other: _____	

I Understand That: This authorization will expire one year from date signed. I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Minneapolis Radiation Oncology, P.A. in writing. I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable). I may inspect or copy any information used or disclosed under this agreement. If the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient/Parent/Legal Representative Signature (*required*) Date Signed (*required*)

_____

Printed Name of Person Signing (*if other than patient*)