MRO

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

Purpose of Release: ☐ Request of Individual ☐ Continued Patient Care ☐ Insurance ☐ Legal Purpose ☐ Other _____

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)