



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)