BECKER
ORTHOPEDICS
Advanced skills and experience for the results you deserve
3501 Health Center Boulevard, Suite 2440
Bonita Springs, Florida 34135
Phone: 239-949-3045 Fax: 239-949-3015

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT	Patient name (print)			Date of Birth
	Street Address			
	City	State	Zip	Phone #
Health Information Released FROM: (***Who*** has the information you want released?)	Name			
	Street Address			
	City	State	Zip	Fax #
Health Information Released TO: (***Where*** do you want the information sent?)	Name			
	Street Address			
	City	State	Zip	Fax #

Health Information to be Released:

(***What*** records do you want released?)

For condition or dates of treatment:_____

- € Complete medical record (with x-ray/MRI images)
- € Complete medical record (without x-ray/MRI images)

OR to only release specific portions of your health information, indicate the categories to be released:

€ Office notes	€ MRI reports	€ X-ray images (CD)
€ Operative reports	€ EMG reports	€ MRI images (CD)
€ Physical therapy notes	€ Other_____	

Purpose of Release:
(***Why*** is it needed?)

€ Personal use	€ Legal*	€ Other _____
€ Continued care	€ Insurance*	

*There may be a charge/fee for copies of records under MN Statute 144.292.

Authorization/Revocation

By signing this authorization I understand the following:
This form expires one year from the dated I sign it unless otherwise indicated here: _____.
I am requesting that the health information marked above be released to the person, clinic or organization above. I may revoke this consent at any time in writing to Minneapolis Orthopaedics. If I do not sign this form, I will still be treated. Upon release, this health information is no longer protected by Minneapolis Orthopaedics and may be released to a third party. A faxed/copy of this authorization is as valid as the original.

Signature _____**Date:** ____/_____/____

Or legally authorized representatives signature_____
Representative's relationship to patient € Parent € Guardian € Other _____