SUMMIT ORTHOPEDICS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION:	Patient Full Name (print):		DOB:
	Address (City, State, and Zip Code):		
	Phone Number:	Email Address:	

HEALTH INFORMATION RELEASED FROM:	☐ Summit Orthopedics, LTD. 710 Commerce Dr. #200, Woodbury, MN 55125 **–OR–**		Phone: 651–968–5125 Fax: 651–968–5907
	☒ Name of Organization/Clinic: Orthopaedic & Fracture Clinic		Attn:
	Address (City, State, and Zip Code): 35 State Avenue, Faribault, MN		
	Phone Number:	Fax Number:	

HEALTH INFORMATION RELEASED TO:	Name of Organization/Clinic: Summit Orthopedics		Attn:
	Address (City, State, and Zip Code): 710 Commerce Drive Suite 200, Woodbury, MN		
	Phone Number: 651-968-5125	Fax Number: 651-968-5907	

HEALTH INFORMATION TO BE RELEASED:	☐ Specific Date/Year of Treatment_____				
	☐ CD of Images	☐ Doctor Notes	☐ Therapy Notes	☐ Operative Report	
	☐ Injection Notes	☐ Lab Reports	☐ Radiology Reports	☐ EMG Report	☐ Billing Statement
	☒ Other Transfer of patient chart				
	The Following Requires Special Consent by Law and must specifically be requested in order for it to be released:				
	☐ Chemical Dependence Program		☐ Psychotherapy Notes		
DELIVERY METHOD:	☒ Paper/Mail	☐ Fax	☐ CD of images only (Mail)		
PURPOSE FOR RELEASE:	☐ Personal Use	☒ Continued Care	☐ Marketing (Sharing testimonial for Summit Orthopedics)		
	☐ Other_____				

I understand that by signing this form, I am requesting that the health information specified be sent to the third party listed above. I understand that I may revoke this request at any time in writing to Summit Orthopedics. The revocation will not apply to records already released. Summit Orthopedics will not condition treatment on whether I sign this authorization. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

This consent will end one year from the date the form is signed (but consents for testimonials will expire as soon as administratively practicable after your request).

Print Name _____ Signature _____ Date _____

Authorized Person's authority to sign (proof required): ☐ Patient is a Minor ☐ Power of Attorney or Legal Representative ☐ Other_____

Summit Orthopedics, Ltd. includes its clinics, surgery centers, diagnostic imaging centers, recovery suites, bracing and orthotics, the components of Minnesota Occupational Health that are subject to HIPAA, and the Woodbury Ambulatory Surgery Center, LLC.

Released By:_____ Date:_____ MRN:_____ Physician:_____