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 Drive Suite 200 Woodbury MN, 55125)	☐ Other (Name of Organization/Clinic):	
		Address (City, State, and ZIPCode):	
		Phone Number:	Fax Number:

HEALTH INFORMATION RELEASED TO:	☐ Self (Address listed above)	☐ Name of Third-Party Organization/Clinic:	
		Address (City, State, and ZIP Code):	
		Phone Number:	Fax Number:
		Email Address (if to be sent by email):	

HEALTH INFORMATION TO BE RELEASED:	☐ Specific Date/Year of Treatment_____				
	☐ CD of Images	☐ Doctor Notes	☐ Therapy Notes	☐ Operative Report	☐ Surgery Chart
	☐ Injection Notes	☐ Lab Reports	☐ Radiology Reports	☐ EMG Report	☐ Billing Statement
	☐ Other (for example, specific body part, or date range of treatment) _____				
DELIVERY METHOD:	☐ **U.S. Mail** (to the address indicated in the "Health Information Released To" section above)				
	☐ **Email** (to the address indicated in the "Health Information Released To" section above)				
	☐ **Fax** (to the number indicated in the "Health Information Released To" section above)				
	☐ **CD of Images** (required for images and will be sent by U.S. Mail to the address indicated in the "Health Information Released To" section above)				
	☐ **In-person pickup at the Summit office location noted here**: _____				
PURPOSE FOR RELEASE:	☐ Personal Use	☐ Continued Care	☐ Disability	☐ Insurance	☐ Legal
	☐ Workers' Compensation	☐ 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 understand that records released may include information received from other third parties. I am aware that some requests may incur a fee as allowed by law.
This authorization will end one year from the date the form is signed. If you want to end on a sooner date, enter the date here: _____

_____	_____	_____
Print Name of Patient or Representative	Signature	Today's Date

Relationship/Authority (If you are not the patient, list your relationship/authority to sign on patient's behalf (examples: parent, legal representative, power of attorney for healthcare, etc.). Representatives signing this form on behalf of a patient may be requested to submit documentation of the relationship/authority.

_____	_____	_____
Released to if other than patient	Relationship	Today's Date

FOR INTERNAL USE ONLY:	Released By:_____	Today's Date:_____