PAIN CENTERS OF MINNESOTA - CHASKA

3000 Hundertmark Road, Suite 200
Chaska, MN 55318
P: 763.201.8191
F: 763.201.8192

Patient's Request to Release Protected Health Information from an Authorized Facility

Patient's Legal Name _____ **Date of Birth** _____
Previous Name _____ **Phone Number** _____

1. **Please release my records from**:

Clinic or Organization: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ Fax: _____

2. **Please release my records to**:

Pain Centers of Minnesota
3000 Hundertmark Road Suite 200 Chaska, MN 55318
Phone: 763-201-8191 Fax: 763-201-8192

These are the records I would like to release pertaining to my _____ pain:

□ 3-5 most recent clinic notes □ Procedure/Injections Notes
□ Physical Therapy Notes □ X-ray, MRI, CT, EMG Reports
□ Chiropractic Notes □ Lab Reports □ Surgical Notes
Additional Records Needed: _____
Date records are needed by: _____ or STAT/ASAP – required for today's treatment

3. **Purpose:** □Continued care by another provider □Insurance claim □Personal use
□Social Security Disability □Attorney review □Other_____

4. **The following information requires special consent by law**.

Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:
□Chemical dependency program □Psychotherapy notes □AIDS/HIV

5. **I understand the following:**

-Information in the chart that was not generated by Metropolitan Surgical Center will not be released to another facility. (We recommend that the original facility be contacted to obtain these records.)
-I understand that I can request, in writing, that the authorization be cancelled at any time.
-I understand that once Metropolitan Surgical Center has disclosed the health care information I have authorized, Interventional Spine and Pain Physicians' has no control over the information and that this information may no longer be protected by privacy laws.
-Metropolitan Surgical Center may not provide treatment to any patient that refuses to sign an authorization for release of Protected Health Information.
-This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified.
-A photocopy/fax of this authorization will be treated in the same way as an original.

_____ _____
Patient Signature or Representative Date

_____
Printed Name
If a Representative Signs, state the Representative's Authority: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED