Patient's Consent and Authorization to Disclose Health Information

Patient's Legal Name ____________________________________ **Date of Birth** _________________________

Previous Name(s) ____ **Phone Number** _______________________

1. **I authorize the release my health information from (cross out any that do NOT apply)**:

iSpine Clinics
9645 Grove Circle N, Suite 200, Maple Grove, MN 55369
Phone: 763-201-8191; Fax: 763-201-8192

Anesthesia Associates
9645 Grove Circle N, Suite 200, Maple Grove, MN 55369
Phone: 763-201-8191; Fax: 763-201-8192

Metropolitan Surgical Center
9645 Grove Circle N, Suite 200, Maple Grove, MN 55369
Phone: 763-201-8191; Fax: 763-201-8192

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

2. **Please release my health information to**:
Clinic or Organization: ____

Address: ____ City: ____________________________

State: ________ Zip Code: __________ Phone: ______________________ Fax: _______________________

3. **Purpose for Release:** □Continuing Care □Insurance □Personal use □Disability □Legal □Other______________

4. **Information to Be Released:**
□ All records and information relating to my treatment.
□ Only records and information relating to the following:

□ Demographics	□ Lab Reports	□ History and Physical
□ Pathology Reports	□ Discharge Summary	□ Hospital & Operative Reports
□ Clinic Notes	□ EKG/ECHO Reports	□ Emergency Room Report
□ Consultation Reports	□ Hospital & Operative Reports	□ Electronic Medical Record Review
□ Other __________________		

Dates of Service: ___________________________ (All dates, unless specified)

All information relating to my Alcohol and/or Drug Abuse, Behavioral Health & HIV, if any, will be released unless I prohibit this release by initialing below:

- Do **not** release my Alcohol and/or Drug Abuse information: __________
- Do **not** release Behavioral Health information: __________
- Do **not** release HIV (AIDS) related information: __________

5. **I understand and agree with the following statements:**

- This Patient's Consent and Authorization to Disclose Health Information applies to information created and maintained by the clinic indicated above (iSpine Clinics, Anesthesia Associates, Metropolitan Surgical Center and/or Pain Centers of Minnesota – Chaska) (the "Clinic"), which may include information obtained from other health providers or organizations.
- This Consent will be valid for one (1) year from the date indicated below unless a different expiration date or event is specified here: _______________________.
- I can revoke (cancel) this Consent at any time by notifying the by the Clinic in writing. Any such revocation will not apply to information released in reliance on this Consent before the Clinic received my revocation notice.

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- The Clinic cannot control how my released information is used, disclosed, or protected, and state and federal privacy laws may no longer protect the confidentiality of this information.
- A photocopy, electronic copy, or faxed copy of this Consent will be treated the same way, and have the same effect, as the original copy of this Consent.
- The Clinic will not condition my treatment, payment, enrollment, eligibility, or benefits on whether I sign this Consent.

______________________________	______________________________
Signature of Patient or Patient's Representative	Representative's relationship to Patient (if Representative signs on behalf of Patient)
______________________________	______________________________
Name of Patient or Representative (please print)	Date