Minnesota Institute for Pain Management

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PRINT PATIENT'S LEGAL NAME: _____ **Birth Date:** _____

Previous Name(s): _____ Phone: _____

1. **Please release my records from and to:** (Who has or needs your records? Please list the hospital, clinic and/or entity.)
   Name: _____
   Address: _____ City: _____ State: __ Zip: _____
   Phone: _____ Fax: _____

2. **Release the records marked below for this condition or date(s) of treatment:** From _____ To: _____
   (if blank, we will release 1 year's worth of most recent records.) Please check records to be released:
   ☐ Pertinent clinic records (office visit, lab/radiology results, medications, immunizations)
   ☐ Pertinent hospital records (emergency, operative or discharge report, history and physical, lab/radiology results)
   ☐ X-ray/Radiology reports ☐ Emergency/Urgent Care ☐ EKG reports
   ☐ Other – please specify _____

4. **Purpose:** (Check Mark) Continuing Care ☐ Insurance ☐ Personal Use ☐ Legal ☐ Other ☐

4. **I understand that:**
   The release of records listed in Section 2 may include detailed information of treatment for mental health, chemical dependency, genetic conditions, and AIDS/HIV.
   If I have received treatment for any of these conditions, may these records be included:
   (Check One) YES ☐ NO ☐

If I change my mind, I may write to Minnesota Institute for Pain Management at the address at the top of this release to stop the release of my records. This will not apply to records that have already been released.

Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.

A photocopy of this completed signed form is considered valid if not altered.

I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

This form expires one year from the date I sign it, except in certain situations specified by law.

_____	_____	_____	_____
Date	Signature of patient or authorized person	Initials	If authorized person, print name and description

SUBMIT