ST CLOUD ORTHOPEDICS

1901 CONNECTICUT AVE. S
SARTELL, MN 56377
MAIN 320-259-4100
FAX 320-257-5522
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Authorization for Release of Protected Health Information

Patient Name	Date of Birth	Chart Number

I authorize:
(NAME AND ADDRESS)

St. Cloud Orthopedics
1901 Connecticut Ave. S
Sartell, MN 56377

Fax #: 320-257-5522

To release my health information to:
(NAME AND ADDRESS)

Purpose of Release:
- ☐ PATIENT'S OWN REVIEW
- ☐ CONTINUING CARE
- ☐ INSURANCE CLAIM
- ☐ LITIGATION
- ☐ OTHER_____

Extent of Information to Release:
- ☐ ALL DATES OF TREATMENT
- ☐ DATES OF TREATMENT FROM _____ (MONTH/DAY/YEAR) TO _____ (MONTH/DAY/YEAR)
- ☐ ONLY FROM DR._____
- ☐ AREA OF TREATMENT:_____
- ☐ OTHER: _____

Information to be released: (Please check all that apply)
- ☐ PHYSICIAN NOTES
- ☐ HOSPITAL/SURGICAL REPORTS
- ☐ X-RAY/DIAGNOSTIC REPORTS
- ☐ X-RAY/DIAGNOSTIC FILMS
- ☐ PHYSICAL THERAPY NOTES
- ☐ LABORATORY REPORTS
- ☐ ITEMIZED BILLING STATEMENTS
- ☐ OTHER_____

I understand that any documentation of substance abuse (drugs or alcohol), psychological or psychiatric conditions, sexually transmitted diseases, and HIV/AIDS will be released as part of my record UNLESS I INITIAL BELOW:

DO NOT RELEASE: (INITIAL TO PROHIBIT RELEASE)
- ☐ DRUG/ALCOHOL ABUSE
- ☐ STDs
- ☐ MENTAL HEALTH
- ☐ HIV/AIDS

By signing below, I understand the following:
Once my information is released, my records may not be protected under federal privacy regulations, and may be subject to re-disclosure. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may revoke this authorization at any time by writing to St. Cloud Orthopedics, Attn: ROI Dept., but revocation will not apply to information that has already been released. This authorization will automatically expire after one year from the signature date below unless an earlier date is specified here_____.

SIGNATURE OR MARK OF PATIENT, PARENT OF MINOR, OR LEGAL REPRESENTATIVE *(CAN'T BE A DIGITAL SIGNATURE)* — TODAY'S DATE

DECLARE LEGAL AUTHORITY TO SIGN AND ATTACH DOCUMENTATION IF APPROPRIATE

WITNESS SIGNATURE REQUIRED IF PATIENT UNABLE TO SIGN BUT USES X OR A MARK — TODAY'S DATE

The requesting party may be subject to a charge for the release of information. Please contact the Release of Information Department at St. Cloud Orthopedics for fee information.