The Orthopaedic & Fracture Clinic
1431 Premier Drive
Mankato, MN 56001-0676
Tel: 507-386-6600

Authorization to Release and Obtain Protected Health Information

1. Patient Information

Patient Name *(First, Middle, Last)*	**Previous Names**
Address	**Birthdate** *(mm/dd/yyyy)*
City/State/Zip	**Phone Number**

2. Release Information From

- ☐ The Orthopaedic & Fracture Clinic, P.A.
  Continue to the next applicable section
- ☐ Other, specify organization or individual below

Name/Facility
Address
City/State/Zip
Phone Number
Fax Number

3. Release Information To

- ☐ The Orthopaedic & Fracture Clinic, P.A.
  Select the department records should be sent
  - ☐ Main: eFax 507-385-0952 | Fax 507-625-5971
  - ☐ MRI: Fax 507-388-1457
  - ☐ Spine | Surgery Scheduling: Fax 507-388-2596
- ☐ Other *Specify organization or individual below*

Name/Facility
Address
City/State/Zip
Phone Number
Fax Number

4. Reason for the Release

☐ Legal	☐ Insurance	☐ Transfer of Care
☐ Worker's Compensation	☐ Self (personal copy)	☐ Medical Leave/Disability
☐ Continuity of care	☐ MRI Safety	☐ Other: _____

5. Information to be Disclosed

☐ Complete Record	☐ Physician Office Notes	☐ Operative or Procedure Reports
☐ Lab or Pathology Reports	☐ Physical Therapy Notes	☐ CD of Images
☐ Radiology Reports	☐ Chiropractic Notes	☐ Spine Injection Reports
☐ Other: _____		

Pertaining to the following medical condition(s) or body part(s): _____

☐ Entire Record or ☐ Specific Date Range: _____ to _____

Needed for the appointment date of: _____

Over

6. Revocation

I authorize release of my medical records in accordance with the specifications listed above. I understand that this authorization to release or discuss information does not expire unless I specify an expiration date here: _____

7. Authorization

If applicable, this authorization includes release of any records regarding psychiatric care, alcohol and/or drug use disorder, or HIV/AIDS related diagnosis unless otherwise specified in writing.

A photocopy of this authorization shall be considered as valid as the original.

I understand that I may revoke this authorization by sending a written request for revocation to OFC's Health Information Department, at the address specified above, at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once this information is disclosed to a third party, the information may be redisclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, and that I have the right to refuse to sign this authorization.

Signature of Patient/Parent/Guardian or Authorized Representative **Date** (*mm/dd/yyyy)*

Printed Name of Person Signing (if not the patient, *First, Middle, Last***)**

Relationship to Patient, *Legal documentation may be required*

- ☐ Parent
- ☐ Stepparent
- ☐ Legal Guardian
- ☐ Foster Parent
- ☐ Health Care Power of Attorney/Agent
- ☐ Other: _____

8. Copy Fee Information

Patient Requests:

As a courtesy to our patients, The Orthopaedic & Fracture Clinic, P.A. does not charge patients for a personal copy of their medical records or records requested for continuity of care.

Third Party Requests:

The Orthopaedic & Fracture Clinic, P.A. contracts with a medical records service to copy and provide medical requests from our office. The medical records service reserves the right to charge the applicable medical record state fee structure as set forth in the state statute or a reasonable, cost-based fee. Copy charges plus postage will be invoiced to the requestor from the medical records service with the necessary directions to receive the records.

Office Use Only:

OFC Staff Name: _____ Date Received: _____