BLAINE ORTHOPEDIC SURGERY CENTER

Internal Use Only | Account #_____
Pickup Instructions_____

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.*

| | | | |
|---|---|---|---|
| **1. PATIENT INFORMATION** | PATIENT NAME: | | |
| | DOB: / / | PREVIOUS NAME(S): | |
| **2. RELEASE MY RECORDS FROM** | FACILITY NAME: | | |
| | DR. NAME: | | |
| **3. SEND MY RECORDS TO** | NAME: | ATTN TO: | |
| | ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX (For Continuing Care ONLY): | |
| | EMAIL: (Only if you want records sent via encrypted email) | | |
| **4. TYPES OF RECORDS** | BODY PART: | | |
| | DATE(S) OF SERVICE: | | |
| | ☐ Anesthesia Records<br>☐ Radiology Images<br>☐ All Health Records (not including billing or imaging ) | ☐ Billing Statement<br>☐ Operative Note<br>☐ Implant Records | |
| **5. VERBAL DISCLOSURE** | For verbal disclosure, check here: _____ | | |
| | "Verbal disclosure" authorizes BOSC to discuss my care with the person(s) indicated in this section: | | |
| **6. REASON FOR REQUEST** | ☐ Personal Use ☐ Insurance ☐ Workers Compensation<br>☐ Disability ☐ Legal ☐ Continuing Care | | |
| | Do you need imaging on a CD? ☐ Yes ☐ No | | |
| **7. RETURN COMPLETED FORMS TO:** | **MAIL TO:**<br>Blaine Orthopedics Surgery Center<br>11225 Ulysses St NE, Blaine, MN 55434 | **FAX TO:** 763-302-2201<br>**DROP OFF:** At Blaine Orthopedic Surgery Center | |
| | * Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing. | | |

**8. I UNDERSTAND THAT BY SIGNING THE BELOW:**

- I may revoke this authorization at any time by notifying the facility identified above in writing.
- By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed.
- There may be a fee for release of this information and I may be responsible for that fee.
- I am authorizing the release of my personal protected health information to and from the entities I've indicted above
- Treatment will not be denied to me if I do not sign this form.
- This authorization will expire one year from the date I sign on this form.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

*If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.



***Electronic or Typed Signatures cannot be accepted***