2854 Highway 55, STE, 190., Eagan, MN 55121
Phone: 651-644-4277 Fax: 651-644-4018

CONSENT FOR RELEASE OF INFORMATION

Patient Name: ______________________
Other Names: ______________________
DOB: ____________Phone: __________
SSN: ______________________________

Facility/Doctor: ______________________
Address: ____________________________
____
FAX: ______________________________

○ **FROM**: I hereby authorize the above identified provider to release to St. Paul Rheumatology, P.A., information from my medical records.

○ **TO**: I hereby authorize St. Paul Rheumatology, P.A. to release to the above identified provider, information from my medical record.

For the purpose of:

○ Continuing Care ○ Litigation ○ Insurance Claim ○ Transfer of care ○ Workers Comp
○ Specialist ○ Other (Explain) ____

This consent to release information is limited to the following:

○ Medical records regarding treatment for____
(Medical condition or injury) occurring on or about___________________________(date).
○ Including ○ Not including records related to alcohol and/or drug abuse treatment, psychiatric records and/or records relating to communicable diseases.

Specific information from my medical records:

○ History and physical ○ Discharge Summary ○ Operative Report
○ Pathology Reports ○ Consultation Report ○ Laboratory Report
○ X-Ray Reports ○ Emergency Room Record ○ Complete Record
○ Certified Copy ○ All ○ Other____________

I understand that I may revoke the consent at any time. This consent will expire one year from the date of my signature.

I understand that one information is released pursuant to this authorization, the hospital/clinic, their employees and my physician(s) cannot prevent the redisclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of the information. Saint Paul Rheumatology will not condition treatment on whether I sign this authorization.

____
Signature of patient

____
Relationship to patient if signed by guardian

____
Date of signature

____
Reason patient unable to sign

Medical Records were released by: ______________________ on ________________________
Name Date