

Premier Sports and Spine Center
8577 Columbine Rd
Eden Prairie, MN 55344
Phone: 952-479-0043
Fax: 952-944-1673

Print patient's legal name _____ Birth date ____/____/____
Previous name _____
Phone numbers (Home) _____ (Work) _____ (Other) _____

1. Please release my records from: *(Who has your records?)*

Clinic or organization (if not printed above): _____
Address: _____ City: _____
State: _____ Zip code: _____ Phone: _____ Fax: _____

2. Please release my records to: *(Who needs your records?)*

Person, clinic or organization (if not printed above): _____
Address: _____ City: _____
State: _____ Zip code: _____ Phone: _____ Fax: _____

If releasing records to yourself, should the envelope be marked "Personal and Confidential"? Yes No

3. These are the records I would like to release: All pertinent records (except films or slides), or check all that apply below

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> EKG/ECHO reports |
| <input type="checkbox"/> Counselor's discharge summary | <input type="checkbox"/> Lab reports | <input type="checkbox"/> Emergency or urgent care reports |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> X-ray / Radiology reports | <input type="checkbox"/> Psychological tests |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Films / CDs | <input type="checkbox"/> Send to MD only: Pathology slides / blocks |
| <input type="checkbox"/> Outpatient clinic notes | <input type="checkbox"/> Operative reports | <input type="checkbox"/> Other: _____ |

For condition or dates of treatment: _____ *(If blank, we will release 1 year's worth of most recent records.)*
Date records are needed by: _____. *Will records be picked up?* Yes No

- 4. Purpose:** Continued care by another provider Insurance claim Personal use
 Social Security disability Attorney review Other _____

5. I understand the following:

- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the person, clinic or organization named above. This includes details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV.
If I don't want these to be released, I will place a check mark here: _____. I do not want the following records released: _____.
- If I change my mind, I may write to the address in section 1 to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it, or on (expiration date: _____).
- There may be a fee for releasing these records.
- Once the records are released to the person, clinic or organization named above, the clinic or hospital 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.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless treatment is part of a research project.



Date/Time *Signature of patient or authorized person* *Authorized person's authority to sign (proof required)*
Reason patient is unable to sign: Minor Deceased Other: _____