MANKATO SURGERY CENTER

AUTHORIZATION FOR RELEASE OF OR REQUEST FOR INFORMATION

_____   _____
Patient Name   Date of Birth

_____   _____
Street Address   SSN

_____   _____
City, State, Zip   Phone Number

I Authorize Information to be Released to: **Please Send My Records to:**

_____   _____
 Name   Name

_____   _____
Street Address   Street Address

_____   _____
City, State, Zip   City, State, Zip

☐ **I or my representative will pick up my records at 1411 Premier Drive, Mankato, MN 56001**
*** *A photo ID will be required for records released directly to an individual*** *

Information to be released (MUST CHECK ALL THAT APPLY):

☐ Operative Notes   ☐ Appointment Information   ☐ Account Information
Other:_____

For the following date(s) of treatment or condition:_____

Please Note: Only information and/or records generated from this location can be released.

I am requesting this information be released for the following purpose:
☐ Continued Care   ☐ Insurance   ☐ Legal   ☐ Personal Use

Other:_____

- A copy of this authorization shall be considered as valid as the original.
- I understand I may revoke this authorization by written request at any time to Mankato Surgery Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire one year from the date of my signature, or a lesser period of time as specified here: _____
- I understand that once information is released pursuant to this authorization, Mankato Surgery Center cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- I understand there may be a charge associated with the Release of Information Services rendered.
- I understand that Mankato Surgery Center will not condition the provision of treatment on whether I sign this authorization form, except in the following situations:
  • If the medical information to be disclosed will result from treatment for research purposes, Mankato Surgery Center will not provide the treatment if I am unwilling to sign this authorization form.
  • If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Mankato Surgery Center will not provide the treatment if I am unwilling to sign this authorization form.

_____   _____ _____
Signature of patient/legal representative   *   Legal representative's authority to sign   Date
                                                (parent, legal guardian, health care power of attorney, etc.)

* Authorized representative may be required to submit copies of legal documents supporting his/her authority to act on a patient's behalf

Please fax completed authorization to 507-388-6913 Attn: Medical Records, or mail to Mankato Surgery Center, Attn: Medical Records, 1411 Premier Drive, Mankato, MN 56001

Requests will be processed within 10 business days.