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 Report ☐ Billing/Account Information ☐ Anesthesia Record ☐ Complete Record

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 (parent, legal guardian, health care power of attorney, etc.)	Date

* 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.