ST. PAUL Surgeons LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name **Date of Birth**

Address

City **State** **Zip** **Daytime Phone**

I authorize St Paul Surgeons ☐ **To obtain from:** ☐ **To release to:**

Name of Person, Institution, Agency, Clinic, Facility, Company or Firm

Address

City **State** **Zip**

Medical Information to be disclosed:

- ☐ Clinic Visits
- ☐ Special Tests
- ☐ Lab Reports
- ☐ Hospital Reports
- ☐ Occupational Health
- ☐ Worker's Comp
- ☐ All Records

**Correspondence and outside records will not be released to another facility. Such information must be obtained from the original source.*

Dates of service: ☐ From _____ to _____ or ☐ All Dates

Reason for release:

- ☐ Legal
- ☐ Consult/Second Opinion
- ☐ Insurance Claim Report
- ☐ Out of Town Move
- ☐ Selected new physician
- ☐ Personal Use
- ☐ Insurance Changed

STATEMENT OF AUTHORIZATION: I authorize the above provider to release the information marked above to the recipient. I understand that I may revoke this consent at any time by giving written notification to St Paul Surgeons. A copy or fax of this authorization will be treated in the same manner as the original. I understand that this release will automatically expire twelve months from the date of my signature. I DO NOT authorize further release to any third party. I understand that once information is released as specified in this authorization, this clinic, employees, and physicians cannot prevent the re-disclosure 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 re-disclosure of that information.

Signature of Patient/Guardian_____

Date _____Relationship _____