

**AUTHORIZATION TO RELEASE RECORDS**

**SPINE & SPORTS INSTITUTE**

9325 Upland Lane North  
Suite 230  
Maple Grove, MN 55369  
Telephone: (763) 315-0466  
Fax: (763) 315-0884

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

SOC. SEC. NUM.: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

This will authorize \_\_\_\_\_ to release to Spine & Sports Institute, information  
(clinic, hospital, Doctor's office)

from the medical records maintained while I was a patient at the above named facility. I hereby acknowledge that a photocopy of this authorization shall be considered and construed as being as effective as the original.

The information to disclose is:

- |   |  |
|---|--|
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Operative Reports   |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports   |
| <input type="checkbox"/> History and Exams    | <input type="checkbox"/> X-Rays with Reports |
| <input type="checkbox"/> Lab Reports          | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> ALL MEDICAL RECORDS  |  |

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATION OR STATUS IF SIGNED BY ANYONE OTHER THAN PATIENT