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:

Discharge Summary	Operative Reports
Consultation Reports	Pathology Reports
History and Exams	X-Rays with Reports
Lab Reports	Other_______________________________________
ALL MEDICAL RECORDS	

____ ______/______/______
SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE DATE

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RELATION OR STATUS IF SIGNED BY ANYONE OTHER THAN PATIENT