Midwest Spine & Brain INSTITUTE

651-430-3800 or 800-353-7720
Fax: 651-259-4584

FOR INTERNAL USE
Faxed ___
Mailed ___

RELEASE OF RELEASE OF INFORMATION

Incomplete request cannot be processed

PATIENT INFORMATION	Name:_____ Date of Birth:_____ Address: _____Day Phone#_____ City:_____ State:_____ Zip_____
Clinic where you saw Provider (WHO has the information you want released?) C**heck box of location(s) where you have been seen.**	☐ Midwest Spine & Brain Institute ☐ Edina ☐ Roseville ☐ Allina Clinic ☐ Apple Valley Clinic ☐ Gold Key St. Paul ☐ United Pain Center ☐ Stillwater ☐ St. Croix Regional Medical Center, St. Croix Falls WI
Receiving Party (Where do you want the information sent? Who may have this information?)	Name_____ Address_____ Day Phone#_____ City: _____State: _____Zip_____
Information to be released (What do you want sent or released? Check the appropriate box)	I authorized MSBI to discuss my care with the named entity(ies) listed above ☐ Routine Record Set (indicate dates of service)_____ ☐ Billing Records ☐ Copies of Images/Films ☐ ALL Records ☐ Other Forms **Only Record Types checked:** ☐ Discharge summary/note ☐ Radiology ☐ History and Exam Note ☐ PT Notes ☐ Operative Reports ☐ Consultations ☐ Progress/Clinical Notes ☐ Laboratory ☐ Injection Reports
Release Instructions (How and When do you want the information?)	**Date Information is needed:** _____ Copies of Images/Films* MSBI only releases images done by MSBI Release Method ☐ Paper ☐ CD
Purpose of Release (Why is it needed?)	☐Continuing Care ☐ Transfer of Care ☐ Disability / Social Security ☐ Insurance ☐Personal Review ☐ Litigation/Legal

I understand that by signing this form, I am authorizing the release of health information specified to the third party named above. I may revoke this consent at any time by writing to the named organization. If I revoke this authorization, the organization will no longer disclose my information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when the health information specified is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named is a health care provider it will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form, except in the following situations: (i) if the medical information to be disclosed will result from treatment for research purposes, the provider will not provide the treatment if I am unwilling to sign this authorization form; and (ii) 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, the provider will not provide the treatment if I am unwilling to sign this authorization form. If I choose not to sign this form and the organization named is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed: (unless earlier date is indicated in writing)

Patient's Signature:_____Date:____/____/_____

Or Legally Authorized Representative's Signature: _____Date:____/____/___

Representative's relationship to patient (parent, guardian, etc.): _____

1950 Northwestern Ave Suite 102 Stillwater, MN 55082
Locations throughout the Twin Cities and western Wisconsin
MidwestSpineInstitute.com

ALLOW 2 WEEKS TO PROCESS REQUEST

Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R