Northland Plastic Surgery

Authorization for Release of Confidential Medical Information

1420 London Rd, Ste 101
Duluth, MN 55805

_____ _____/_____/_____

Patient Name: Last First Date of Birth

I hereby authorize:
(Name and Address of releasing facility)

_____
_____
_____
_____

To Release Information To:
(Individual name, facility/organization and address)

_____
_____
_____
_____

EXTENT OF INFORMATION TO BE SENT:

_____ Including all dates of treatment

_____ Between the dates of _____ to _____

PURPOSE OF DISCLOSURE:

_____ Continuing care _____ Legal

_____ Claim payment _____ Personal

_____ Other: _____

TO INCLUDE FINDINGS AND RESULTS OF:

_____ Physician notes

_____ X-ray reports

_____ X-ray films

_____ Laboratory reports

_____ Diagnostic test reports

_____ Photos

_____ All available records

_____ Other (Please specify)

_____

_____

I UNDERSTAND:

- the expiration of this authorization is one year.
- that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- by authorizing this use or disclosure of information, there will be no conditions placed on my healthcare or payment for my healthcare.

_____ _____ _____

SIGNATURE OF PATIENT, PARENT OF MINOR, OR PERSONAL REPRESENTATIVE | RELATIONSHIP | DATE