Northland Plastic Surgery
4316 Rice Lake Rd, Ste 109
Duluth, MN 55811

AUTHORIZATION FOR RELEASE OF CONFIDENTAL MEDICAL INFORMATION

I, _____, _____, hereby authorize
NAME OF PATIENT **DATE OF BIRTH**

_____ to release medical information
FACILITY OR PERSON TO RELEASE INFORMATION

and copies of my health records.

TO BE SENT TO: _____

_____

_____

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)

_____

_____

- The expiration of this authorization is one year.
- You 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.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure 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 your healthcare or payment for your healthcare.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

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