

SURGICAL SPECIALISTS OF MINNESOTA

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name _____ DOB _____ SSN _____

I hereby authorize: **Surgical Specialists of Minnesota**

To disclose the above named individual's health information to:

Name Address

City State Zip Code Telephone Number

Description of information to be released (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Most recent history and physical |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Radiology Films-specify type _____ | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Pathology Reports | |
| <input type="checkbox"/> Other _____ | |

I understand that my health records may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse, or any such related information.

Description of the purpose of the use and/or disclosure:

- | | | |
|--|---|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Disability/Social Security |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Personal Use | | |
| <input type="checkbox"/> Other (please describe) _____ | | |

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my health care will not be affected if I do not sign this form.

Signature of Patient or Patient's Representative

Relationship to patient

Printed Name of Patient or Patient's Representative

Date