Authorization for Release of Protected Health Information From Institute for Athletic Medicine

Office use only MR#_____

Print patient's legal name: _____ Birth date: _____/_____/_____

Previous name(s):_____ Phone:_____

1. **Please release my records from:**

   Institute for Athletic Medicine, Central Medical Records
   400 Stinson Blvd NE RM #3047
   Minneapolis, MN 55413
   Phone: 612-331-1845; Fax: 612-378-4936

2. **Release the records marked below for this condition or date(s) of treatment:** _____
   (if blank, we will release 1 year's worth of most recent records.)

   ☐ All Physical Therapy (PT) Records ☐ PT Physician Orders ☐ OT Records
   ☐ Initial PT Evaluation ☐ PT Discharge Note ☐ Chiropractic Records
   ☐ PT Progress Notes ☐ PT Flowsheets
   ☐ Other (please specify): _____

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*

   Name: _____
   Phone:_____Fax:_____
   Address:_____City:_____ State:_____ Zip: _____

4. **Delivery/format:** ☐ Paper copy ☐ Mail ☐ Fax ☐ Will pick up _____
   Date needed by: _____

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other _____

6. **I understand that:**
   - Except for psychotherapy notes (not included in medical record), the release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released**: _____
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - I approve the release of records for future visits, starting from the date I sign this form through:_____.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - If I do not sign this form, I will still get medical treatment, unless treatment is part of a research project.
   - This form expires one year after I sign it, or on _____, except in certain situations specified by law.

_____	_____	_____	_____
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and description of authority to sign for patient (may require proof)***