Midwest Physical Therapy

Authorization to Release Health Information

1. Patient Information:	Name: _____ Date of Birth: _____ Phone Number: _____
2.Health Information to be Released: **TO FROM**	Midwest Physical Therapy, *An independent subdivision of Advanced Spine & Pain Clinics of MN* 2801 S. Wayzata Blvd, Minneapolis MN 55405 Ph: 612-707-0169 Fax: 612-465-1603
3.Health Information to be Released: **TO FROM**	Person/Clinic:_____ Street Address: _____ City/State/Zip: _____ Phone: _____ / Fax: _____
4.Information to be Released:	____ All health information from ___/___/____ to present. (Excludes chemical dependency program and psychotherapy notes) ____ Radiology Reports/Imaging ____ Other information _____
5.Authorization/Revocation	I understand that by signing this form, I am requesting that my health information be shared as specified in sections 2 and 3. I may stop this consent at any time by writing to the entities named in sections 2 or 3 and is effective only when my stop notification is received. I understand that the health information specified in section 4 could be re-disclosed by the third party that received it and may no longer be protected by federal or state privacy laws. **This consent will end one year from the date the form is signed unless I revoke my consent in writing.**
6. Patient's Signature	_____ _____ Signature of patient Date _____ _____ Signature of authorized representative (if applicable) Date I hereby state that I am a legal guardian or authorized representative of the above named patient. _____ Relationship to patient

A photocopy of this authorization is as valid as the original.