Burnsville Surgery Center

Authorization for Release of Information

Please attach this sheet with the requested records!

PATIENT	Name: _____ Date of Birth: _____ Maiden OR Other Name(s): _____
HEALTH INFORMATION RELEASED FROM	☐ **BURNSVILLE SURGERY CENTER** 14551 County Rd. 11, Suite 110, Burnsville, MN 55337 Phone: (952) 222-1818 Fax: (952) 222-1817 ☐ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
HEALTH INFORMATION RELEASED TO	☐ **BURNSVILLE SURGERY CENTER** 14551 County Rd. 11, Suite 110, Burnsville, MN 55337 Phone: (952) 222-1818 Fax: (952) 222-1817 ☐ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
DELIVERY	☐ Fax ☐ Mail ☐ Pick up (photo ID required) ☐ Other: _____
PURPOSE	☐ Continuity of Care ☐ Insurance ☐ Disability ☐ Legal ☐ Personal ☐ Other
HEALTH INFORMATION TO BE RELEASED	☐ Procedure/Injection Notes ☐ Lab Results ☐ Radiology Reports ☐ Other, as listed: _____ All information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below: _____ DO NOT RELEASE alcohol/drug use or abuse records _____ DO NOT RELEASE mental health records _____ DO NOT RELEASE HIV/AIDS records
DATES OF TREATMENT TO BE RELEASED	☐ Please release 6 months of most recent records ☐ Please release 12 months of most recent records ☐ Please release records for the period of _____ to _____.
AUTHORIZATION/REVOCATION	This authorization will terminate in one year unless otherwise specified: _____. This signed authorization allows release of the requested records to BURNSVILLE SURGERY CENTER. Providing the information has not already been disclosed, this release may be revoked at anytime by sending a request in writing to BURNSVILLE SURGERY CENTER. A photocopy of this signed authorization is as valid as the original. I understand that once the information is released, the information is subject to re-disclosure and may not be protected by the federal privacy regulation. BURNSVILLE SURGERY CENTER WILL NOT release medical records obtained from another health care provider or facility. Patient Signature: _____ Date: _____