The Orthopaedic & Fracture Clinic

AUTHORIZATION TO RELEASE/DISCUSS INFORMATION

PATIENT:	Name	
	Previous Names	
	Birthdate	Phone #
	Address	City/State/Zip

I HEREBY AUTHORIZE: The Orthopaedic & Fracture Clinic, P.A.
1431 Premier Drive Fax: 507-625-5971
Mankato, MN 56001

To Release or Discuss:	Physician/Facility/Caregiver/Family Member/Other	
	Phone #	Fax #
	Address	City/State/Zip
	Relationship to Patient	
	Limitations or Instructions	

FOR THE PURPOSE OF (Please Circle):

Litigation / Insurance / Self (Personal Copy) / Transfer of Care

Disability / Work Comp / Other

MEDICAL RECORDS REGARDING (Please Circle):

Physician Office Notes / Operative or Procedure Reports / Lab or Pathology Reports

Radiology Reports / CD of Images / Other:

BODY PART: _____

ENTIRE CHART (*please circle*) or SPECIFIC DATE RANGE: _____ to _____

(OVER)

Updated 10/7/2016

Physicians

Michael M. Kearney, M.D.
Paul C. Matson, M.D.
Steven B. Curtis, M.D.
John A. Springer, M.D.
Scott R. Stevens, M.D.
Edwin D. Harrington, M.D.
Kyle C. Swanson, M.D.
Gordon D. Walker, M.D.
Jesse C. Botker, M.D.
Thomas R. Jones, M.D.
Thomas E. Nelson, M.D.

Administration

Andrew R. Meyers, CEO

Services

OFC Express
Orthopaedic Urgent Care

OFC Physical Therapy
Sports Medicine

OFC Back Care Center

Mankato Regional Imaging at OFC

Locations

Mankato
1431 Premier Drive
Mankato, MN 56001
(507) 386-6600

Hutchinson
1095 Highway 15 South
Hutchinson, MN 55350
(320) 484-4400

www.ofc-clinic.com

NEEDED FOR THE APPOINTMENT DATE OF: _____/_____/_____

I authorize release of my medical records in accordance with the specifications listed above. I understand that this authorization to release/discuss information does not expire unless I specify an expiration date here: _____.

If applicable, this authorization includes release of any records regarding psychiatric care, alcohol and/or drug abuse, or AIDS-related disease diagnosis unless otherwise specified in writing.

A photocopy of this authorization shall be considered as valid as the original.

I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once this information is disclosed to a third party, the information may be re-disclosed by the person or entity that receives the information and may no longer be protected by federal privacy regulations.

_____ _____

(Date) **(Signature of Patient/Parent/Guardian or Authorized Representative)**

_____ _____

(Date) **(Signature of OFC Witness)**

Fee Information:

Patients

As a curtesy to our patients, The Orthopaedic & Fracture Clinic does not charge patients for a personal copy of their medical records or records requested for continuity of care.

Third Party

The Orthopaedic & Fracture Clinic does contract with a medical records service to copy and provide medical requests from our office. The medical records service reserves the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to the requestor from the medical records service with all of the necessary directions to receive the records.