ORTHOPAEDIC & FRACTURE CLINIC
Health Information Management
1431 Premier Drive, Mankato, MN 56001
Tel: 507-386-6602 | Email: HIM@ofc-clinic.com

Authorization to Release Medical Information

1. Patient Information

Patient Name	**Previous Names**
Address	**City/State/Zip**
Date of Birth	**Phone Number**

2. Release Information From

☐ OFC: *Continue to the next applicable section.*
☐ Other: *Specify the organization or individual below.*

Name/Facility
Address
City/State/Zip
Phone Number
Fax Number

3. Release Information To

☐ OFC: *Indicate where the records should be sent below.*
- ☐ Main: eFax 507-385-0952 | Fax 507-625-5971
- ☐ MRI: Fax 507-388-1457
- ☐ Spine | Surgery Scheduling: Fax 507-388-2596

☐ Other: *Specify the organization or individual below.*

Name/Facility
Address
City/State/Zip
Phone Number
Fax Number

4. Reason for the Release

☐ Legal	☐ Insurance	☐ Transfer of Care
☐ Worker's Compensation	☐ Self (personal copy)	☐ Medical Leave/Disability
☐ Continuity of care	☐ MRI Safety	☐ Other: _____

5. Information to be Disclosed

☐ Complete Record	☐ Physician Office Notes	☐ Operative or Procedure Reports
☐ Lab or Pathology Reports	☐ Physical Therapy Notes	☐ CD of Images
☐ Radiology Reports	☐ Chiropractic Notes	☐ Spine Injection Reports
☐ Other: _____		

Pertaining to the following medical condition(s) or body part(s): _____

☐ Entire Date Range or ☐ Specific Date Range: _____ /_____ /_____ to _____ /_____ /_____

Date Records are Needed (appointment date): _____ /_____ /_____

6. Consent and Authorization for Release of Information

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

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

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

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization and that I have the right to refuse to sign this authorization.

Revocation

I authorize the release of my medical records in accordance with the specifications listed above. I understand that this authorization to release or discuss information will remain in effect until I revoke it by sending a written request for revocation to OFC's Health Information Department at the address specified above. The revocation will not apply to information already released in response to this authorization.

7. Copy Fee Information

Patient Requests

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

Third-Party Requests

The Orthopaedic & Fracture Clinic contracts with a medical records service to copy and provide medical requests from our office. The medical records service reserves the right to charge the applicable medical record state fee structure as outlined in the state statute or a reasonable, cost-based fee. Copy charges plus postage will be invoiced to the requestor from the medical records service with the necessary directions to receive the records.

8. Authorization

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

Printed Name of Person Signing (if not the patient)

Relationship to Patient: *Legal documentation may be required*

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney/Agent ☐ Spouse/Significant Other

☐ Other: _____

OFFICE USE ONLY

Records to be: ❑ Faxed ❑ Mailed ❑ Other: _____

Notes:

_____

_____

OFC Staff Name: _____ Date Received: _____