Physicians Neck & Back Clinics
of Central Minnesota

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Name: _____ Patient phone number: _____

Address: _____

Date of Birth: _____ Medical Record Number: _____

I authorize the disclosure and use of health information as described below:

1. Information to be disclosed by: (please check one)

____ PNBC
Physicians Neck & Back Clinics
158 19th Street South
Sartell, MN 56377
(320) 253-5385 (ph)
(320) 253-5396 (fax)

_____OTHER, name of facility and/or provider:
_____(name)
_____ (address)
_____ (city, state, zip)
_____(phone)
_____(fax)

2. Information to be received by: (please check one)

____ PNBC
Physicians Neck & Back Clinics
158 19th Street South
Sartell, MN 56377
(320) 253-5385 (ph)
(320) 253-5396 (fax)

_____OTHER, name of facility and/or provider:
_____(name)
_____ (address)
_____ (city, state, zip)
_____(phone)
_____(fax)

Relationship to Patient:
□ Self □ Relative □ Legal Representative □ Healthcare Provider □ Employer
□ Attorney □ Guardian □ Other _____

3. The purpose for which this information may be disclosed:
□ For treatment □ For coordination of care □Payment □ At the request of the individual listed above
□ Other _____

4. What information may be disclosed:
□ Entire Medical Record (includes ALL listed here)
□ Medical Advice
□ Most Recent Physical and History
□ Medication / Allergy Information
□ Other _____
□ Appointment Information
□ Most Recent Discharge Summary
□ Consultation Reports from (provider's name) _____
□ X-ray and/or Imaging Results from _____to _____

5. This authorization expires on the following date, event or condition: _____
This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law.

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the facility listed above.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or request a copy of the health information to be disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by those laws. Information that goes to other persons/entities, if not protected by state or federal privacy laws, could be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

_____ _____
Signature of Patient or Patient's Representative — Date

Note: A photocopy / facsimile of this authorization is valid as original.

_____ _____
Printed Name — Relationship to Patient

_____ _____
Witness — Date