# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:_____ Birthdate:_____
Last First Middle

Patient's Address:_____Phone: _____
Street City State Zip

I Hereby Authorize: _____
Clinic/Doctor's Name and Address

_____
Street City State Zip

To Furnish Medical Information To: **Stillwater Medical Group/Dr. Charles J. Hipp, M.D. Phone: 651-439-1234 Fax: 651-439-9687**
Clinic/Doctor's Name and Address
**921 South Greeley Street Stillwater MN 55082**
Street City State Zip

I have released medical information for the purpose of:

_____ Insurance _____ Legal _____ Counseling _____ Worker's Compensation
_____ Referral Treatment _____ Preplacement Exam _____ Other

If change of clinic:
_____ Moving _____ Dissatisfaction
_____ Convenience of Hours _____ Convenience of Location
_____ Insurance Change;
` Type of insurance: From:_____ To: _____Employer: _____
(if coverage is thru employer)

The information released by this authorization covers the following hospitalization or treatment.
(Please check all appropriate spaces below).

_____ All Records _____ MMPI Interpretation _____ X-Ray Reports
_____ Discharge Summary _____ Social History _____ Psychiatric Evaluation
_____ History & Physical Exam _____ Counseling Reports _____ Pathology Reports
_____ Consultation Reports _____ EKG Reports _____ Lab Reports
_____ Operative Reports _____ EEG Reports _____ Other (specify):
_____

The information released by this authorization shall not be re-released to anyone without the written permission of the patient or patient's parent or legal guardian. The information released by this authorization shall be limited to the information indicated above.

Signature: _____ Date: _____

Or _____ Date: _____
Parent, Legal Guardian, or Authorized Representative (when required)

Witness: _____ Date: _____

I understand that I may revoke this consent at any time and that upon fulfillment of the above-stated purpose, or one year from this date (whichever occurs first), this consent will automatically expire without my express revocation. Please see reverse side for directions and important information regarding completion of this release form.