

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____			Birthdate: _____		
Last	First	MI			
Patient's Address: _____					
Street		City	State	Zip	
Patient's Telephone Number (____) - _____					

This will authorize my **Primary Care Clinic/MD:** _____
(Print Name of Clinic/MD)

To release the following medical information:

- | | |
|---|---|
| <input checked="" type="checkbox"/> History & Physical | <input checked="" type="checkbox"/> EKG |
| <input checked="" type="checkbox"/> Clinical Summary | <input checked="" type="checkbox"/> Laboratory results |
| <input checked="" type="checkbox"/> Procedure/Operative Reports | <input checked="" type="checkbox"/> Stress Test/Treadmill Reports |
| <input checked="" type="checkbox"/> Consultation Reports | <input checked="" type="checkbox"/> Echocardiogram Reports |
| <input checked="" type="checkbox"/> Physician Progress Notes | <input checked="" type="checkbox"/> Stress Echocardiogram Reports |
| | <input checked="" type="checkbox"/> Holter Monitor (include EKG tracings) |

This information is needed for the following purpose(s): **Cardiology appointment at Minnesota Heart Clinic.**

6405 France Ave So, Suite W200, Edina MN 55435. Fax number: (952) 836-3950.

***This authorization will remain in effect a maximum of twelve (12) months from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy or facsimile of this authorization will be treated in the same manner as the original.**

Signature of Patient/Parent/Guardian

Relationship to Patient

Reason Patient is Unable to Sign

Witness

DATE _____