TWIN CITIES ORTHOPEDICS

**Account #:_____**
**(internal use only)**

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.*

| | | |
|---|---|---|
| **Patient** | Name | DOB |
| | Previous Name(s) | Primary Phone |
| | Address | Additional Phone |
| | City | State Zip |

| | | |
|---|---|---|
| **Release my records from** | Name | Dr. Name |
| | Address | |
| | City | State Zip |

| | | |
|---|---|---|
| **Release my records to:** | Name | Dr. Name |
| | Address | Phone |
| **For Verbal Disclosure, check here _____** | City | State Zip |
| | Checking "Verbal Disclosure, authorizes TCO to Identified in this section. | discuss my care with the person(s) I have |

| | | | |
|---|---|---|---|
| **Requests will not be processed if this section is not completed** | ☐ Office Notes<br>☐ X-rays (CD/films)<br>☐ MRI/Radiology Reports | ☐ Lab Reports<br>☐ Hospital Records<br>☐ Therapy, Physical & Occupational | ☐ Itemized Billing<br>☐ HIV/Mental Health/Drug Abuse<br>☐ Body Part _____<br>☐ Date(s) of service _____ |

| | | | |
|---|---|---|---|
| **Reason For Request** | ☐ Personal Use<br>☐ Disability | ☐ Insurance<br>☐ Legal | ☐ Worker's Compensation<br>☐ Continuing Care |

**Date needed by _____/_____/_____** A mm/dd/yyyy format must be entered.
**How would you like to receive this information?**

☐ By mail

☐ Pickup at TCO Clinic (If being released from TCO, records may be picked up at a TCO clinic)
Please specify which clinic you will be picking up the records at _____

| | |
|---|---|
| **I understand that by signing below** | ☐ I may revoke this authorization at any time by notifying the facility identified above in writing.<br>☐ By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed.<br>☐ There may be a fee for release of this information and I may be responsible for that fee.<br>☐ I am authorizing the release of my personal protected health information to and from the entities I've indicated in sections 2 and 3 of this form.<br>☐ Treatment will not be denied to me if I do not sign this form.<br>☐ This authorization will expire one year from the date I sign on this form.<br>**Signature of Patient/Guardian _____ Date _____**<br>**If signed by person other than patient, please send copies of legal documentation for representation* |

TWIN CITIES ORTHOPEDICS

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

***ALLOW UP TO 2 WEEKS TO RECEIVE YOUR INFORMATION***

| **If you were initially seen at any one of these clinics:** | | **Please *print, sign* and send authorization form to:** |
|---|---|---|
| Arlington | 601 West Chandler St | Fax: (952) 456-7020<br>Phone: (763) 504-2729<br><br>Mail: TCO Attn: Records<br>4200 Dahlberg Dr.<br>Golden Valley, MN 55422 |
| Blaine | 11855 Ulysses St. NE | |
| Bloomington | 600 W 98th St | |
| Burnsville | 1000 W. 140th Street | |
| Chaska | 111 Hundertmark Road | |
| Delano | 916 St Peter Ave | |
| Eden Prairie | 12982 Valley View Rd | |
| Edina | 4010 West 65th St | |
| Minnetonka | 15450 MN-7 | |
| Mound | 4695 Shoreline Dr | |
| New Prague | Queen of Peace Hospital | |
| Olivia | 611 E Fairview Ave | |
| Otsego | 8540 Quaday Ave NE | |
| St. Paul | 2155 Ford Parkway | |
| Waconia | 560 South Maple St | |
| Watertown | 204 Lewis Ave S | |

| **If you were initially seen at any one of these clinics:** | | **Please *print, sign* and send authorization form to:** |
|---|---|---|
| Coon Rapids | 3111 124th Ave NW | Fax: (763) 786-3320<br>Mail: 8290 University Ave N, #200<br>Fridley, MN 55432 |
| Fridley | 8290 University Ave NE | |
| Shoreview | 4570 Churchill St | |

| **If you were initially seen at any one of these clinics:** | | **Please *print, sign* and send authorization form to:** |
|---|---|---|
| Maple Grove | 9630 Grove Circle N | Fax: (763) 302-2402<br>Mail: 3366 Oakdale Ave N, #103<br>Robbinsdale, MN 55422 |
| Plymouth | 2855 Campus Dr | |
| Robbinsdale | 3366 Oakdale Ave N | |
| St. Anthony | 2155 Ford Parkway | |

| **If you were initially seen at any one of these clinics:** | | **Please *print, sign* and send authorization form to:** |
|---|---|---|
| Amery | 265 Griffin Street East | Fax: (651) 439-0232<br>Phone: (651) 439-8807<br><br>Mail: 5803 Neal Ave N<br>Oak Park Heights, MN 55082 |
| Hudson | 411 Stageline Road | |
| New Richmond | 535 Hospital Rd | |
| Osceola | 2600 65th Ave | |
| River Falls | 1687 East Division St | |
| St. Croix Falls | 216 South Adams St | |
| Stillwater | 1701 Curve Crest Blvd | |
| Maplewood | 1655 Beam Ave. | |
| Woodbury | 1875 Woodwinds Drive | |
| Lake Elmo | 8650 Hudson Blvd | |
| Wyoming | 5130 Fairview Blvd | |
| St. Paul | 310 North Smith Ave | |