



# Burnsville Surgery Center

## Authorization for Release of Information

**\*Please attach this sheet with the requested records!\***

<b>PATIENT</b>	Name: _____ Date of Birth: _____ Maiden OR Other Name(s): _____
<b>HEALTH INFORMATION RELEASED FROM</b>	<input type="checkbox"/> <b>BURNSVILLE SURGERY CENTER</b> 14551 County Rd. 11, Suite 110, Burnsville, MN 55337 Phone: (952) 222-1818 Fax: (952) 222-1817 <input type="checkbox"/> Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
<b>HEALTH INFORMATION RELEASED TO</b>	<input type="checkbox"/> <b>BURNSVILLE SURGERY CENTER</b> 14551 County Rd. 11, Suite 110, Burnsville, MN 55337 Phone: (952) 222-1818 Fax: (952) 222-1817 <input type="checkbox"/> Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
<b>DELIVERY</b>	<input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Pick up (photo ID required) <input type="checkbox"/> Other: _____
<b>PURPOSE</b>	<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other
<b>HEALTH INFORMATION TO BE RELEASED</b>	<input type="checkbox"/> Procedure/Injection Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other, as listed: _____  All information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below: _____ DO NOT RELEASE alcohol/drug use or abuse records _____ DO NOT RELEASE mental health records _____ DO NOT RELEASE HIV/AIDS records
<b>DATES OF TREATMENT TO BE RELEASED</b>	<input type="checkbox"/> Please release 6 months of most recent records <input type="checkbox"/> Please release 12 months of most recent records <input type="checkbox"/> Please release records for the period of _____ to _____.
<b>AUTHORIZATION/REVOCATION</b>	This authorization will terminate in one year unless otherwise specified: _____. This signed authorization allows release of the requested records to BURNSVILLE SURGERY CENTER. Providing the information has not already been disclosed, this release may be revoked at anytime by sending a request in writing to BURNSVILLE SURGERY CENTER. A photocopy of this signed authorization is as valid as the original. I understand that once the information is released, the information is subject to re-disclosure and may not be protected by the federal privacy regulation. BURNSVILLE SURGERY CENTER WILL NOT release medical records obtained from another health care provider or facility.  Patient Signature: _____ Date: _____