



9875 HOSPITAL DRIVE  
MAPLE GROVE, MN 55369

### AUTHORIZATION FOR RELEASE OF INFORMATION

MR # \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone Number: \_\_\_\_\_

This will authorize \_\_\_\_\_  
(Name/Dept/Address)

to release information to \_\_\_\_\_  
(Name/Title of Person/Organization)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

Information to be released includes records from the following dates: \_\_\_\_\_

Information to be released:

- |   |   |
|---|---|
| <input type="checkbox"/> Cardiac Test Results           | <input type="checkbox"/> Operative Reports        |
| <input type="checkbox"/> Consultation Reports           | <input type="checkbox"/> Pathology Reports        |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Physician Orders         |
| <input type="checkbox"/> EKG Reports                    | <input type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> Emergency Department Reports   | <input type="checkbox"/> Radiology Films          |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Radiology Reports        |
| <input type="checkbox"/> Laboratory Reports: _____      | <input type="checkbox"/> Other (specify): _____   |
| <input type="checkbox"/> Nurses Notes                   |   |

**Reports released may include information about mental status/drug/alcohol and HIV testing results. If there is specific information that you do not want released, please write here:**

\_\_\_\_\_  
\_\_\_\_\_

The information is needed for the following purpose: \_\_\_\_\_

Information to be released via:  Mail  Pick-up  FAX  Courier  Review Only

This authorization will expire upon the earliest of the following dates: 1) twelve months following date of signature on this form, 2) the date the stated purpose is fulfilled, 3) the date I write here \_\_\_\_\_, 4) the date that I revoke this authorization. I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that Maple Grove Hospital has relied on the authorization. A photocopy or facsimile of this authorization shall be treated as valid as the original. I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

Date: \_\_\_\_\_  
Must be filled in

(If Patient's Representative, under what legal authority are you signing?)

- Parent  Guardian  Health Care Agent  
 Other (specify): \_\_\_\_\_

**Maple Grove Hospital will not require you to sign this authorization before providing treatment.**