



ST. CLOUD
**FOOT & ANKLE
 CENTER**

Release of Medical Records Authorization

PATIENT NAME: 	DOB:
PHONE NUMBER: 	ADDRESS:
DATES OF INFORMATION TO BE RELEASED FROM: <input type="checkbox"/> OFFICE NOTES <input type="checkbox"/> X-RAYS REPORTS/PRINTED IMAGINES <input type="checkbox"/> SURGERY REPORTS <input type="checkbox"/> MRI REPORTS (Ordered by our doctors)	REASON FOR DISCLOSURE: <input type="checkbox"/> CONTINUING CARE <input type="checkbox"/> 2ND OPINION <input type="checkbox"/> PERSONAL USE <input type="checkbox"/> ATTORNEY <input type="checkbox"/> OTHER (SPECIFY)
SEND INFORMATION TO (PLEASE INCLUDE COMPLETE ADDRESS) NAME: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ FAX NUMBER: _____	APPOINTMENT DATE (IF APPLICABLE): _____
I AUTHORIZE THE ABOVE PROVIDER TO RELEASE INFORMATION TO THE REQUESTER. A COPY OF THESE RECORDS WILL BE KEPT ON FILE.	
_____ PATIENT/GUARDIAN SIGNATURE	_____ RELATIONSHIP TO PATIENT
_____ DATE	

*****PLEASE ALLOW 5 BUSINESS DAYS TO PROCESS*****

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