MEDICAL RECORDS RELEASE FORM

Patient Information:
Patients Name: _____
Address: _____
Home Phone: _____
Birth date: ____/____/_____

Please transfer my medical records from:
Clinic & Dr's name: _____
Address: _____
City, State, Zip: _____

Please transfer my medical records to:
Clinic & Dr's name: _____
Address: _____
City, State, Zip: _____
In order to ensure your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

These are the records I would like released:
___ All medical records ___ Records dated ____/____/____ to ____/____/____

Purpose of information being released:
__ Continued care by another provider __ Personal use __ Other

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. I may be charged for copies in accordance with state law. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

Signature of Patient or Legally Authorized Representative:
_____
Name & Relationship of legally Authorized Representative to Patient: _____
_____
Reason Patient did not sign:_____
Date: _____ (This authorization will expire 1 year from this date)

Records for the past two years will be sent unless noted otherwise.

St Cloud	Paynesville	Becker
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