Twin Cities Pain Clinic
Authorization for Release of Information

PATIENT	Name:_____Date of Birth:_____ Maiden OR Other Name(s):_____
HEALTH INFORMATION RELEASED FROM	☐ **TWIN CITIES PAIN CLINIC** 7235 Ohms Lane, Edina, MN 55439 Phone: 952-841-2345 Fax: 952-841-2346 ☐ Person/Organization:_____ Address:_____ Phone: _____ Fax: _____
HEALTH INFORMATION RELEASED TO	☐ **TWIN CITIES PAIN CLINIC** 7235 Ohms Lane, Edina, MN 55439 Phone: 952-841-2345 Fax: 952-841-2346 ☐ Person/Organization:_____ Address:_____ Phone: _____ Fax: _____
DELIVERY	☐ Fax ☐ Mail ☐ Pick up (Photo ID Required) ☐ Other:_____
PURPOSE	☐ Continuity of Care ☐ Insurance ☐ Disability ☐ Legal ☐ Personal ☐ Other
HEALTH INFORMATION TO BE RELEASED	☐ Progress/Clinic Notes ☐ Work Reports ☐ Exam Results (lab, radiology reports) ☐ Notes from Case Manager ☐ Psychology Notes ☐ Disability forms/FMLA ☐ 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
DATES OF TREATMENT TO BE RELEASED	☐ Please release 6 months of **most recent** records ☐ Please release 12 months of **most recent** records ☐ Please release records for the period of _____ to _____
AUTHORIZATION/ REVOCATION	This authorization will terminate in one year unless otherwise specified:_____ This signed authorization allows release of the requested records to Twin Cities Pain Clinic. Providing the information has not already been disclosed, this release may be revoked at anytime by sending a request in writing to our clinic. 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. Twin Cities Pain Clinic WILL NOT release medication records obtained from another health care provider or facility. Patient Signature:_____ Date:_____