



Twin Cities Pain Clinic

Physician directed pain management & physical therapy

7235 Ohms Lane
Edina, MN 55439

Tel: (952) 841-2345
Fax: (952) 841-2346
www.twincitiespainclinic.com

RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

For the purpose of medical care, the above patient requests records:

FROM TO

FACILITY/ PHYSICIAN/SELF: _____

ADDRESS: _____

PHONE: _____

FAX: _____

FROM TO

TWIN CITIES PAIN CLINIC
7235 Ohms Lane
Edina, MN 55439
Tel: (952) 841-2345
Fax: (952) 841-2346

► Please release the following records for the period of _____ to _____:

- | | |
|--|--|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Work Reports |
| <input type="checkbox"/> Exam Results (lab, radiology reports) | <input type="checkbox"/> Notes from Case Manager |
| <input type="checkbox"/> Psychology Notes | <input type="checkbox"/> Disability Forms/FMLA |
| <input type="checkbox"/> Other, as listed: | |

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 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 medical records obtained from another health care provider or facility. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization.

► PATIENT SIGNATURE _____ DATE _____

This authorization will expire one year from the signed date above