Metro Foot and Ankle Clinic, PLLC

8001 Highway 7 Suite 200 * St. Louis Park * MN * 55379 Office 952-426-0874 Fax 952-426-0896

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Information Released

To:
Metro Foot & Ankle Clinic
8001 Highway 7 #200
St, Louis Park, MN 55426
Office: 952-426-0874
Fax:952-426-0896

From:
_____
_____
_____

Please Release the Following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Lab Reports
_____ Immunizations
_____ X-Ray Reports
_____ X-Ray Films
_____ EKG Reports
_____ Other Diagnostic Reports (Specify) _____
_____ Other (Specify**)** _____

Including information (if applicable) pertaining to:
_____ Mental Health _____Drug/Alcohol _____HIV/AIDS _____Communicable Treatment

Purpose of Need for Disclosure:

____ Continued Patient Care
_____ Attorney/Legal
_____ Disability Determination
_____ Personal Use
_____ Insurance Claim/Application
_____ Other (Specify)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
I will not hold Metro Foot and Ankle Clinic, PLLC liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness