PAIN CENTERS OF
MINNESOTA - CHASKA

3000 Hundertmark Road, Suite 200
Chaska, MN 55318
P: 763.201.8191
F: 763.201.8192

Patient's Consent to Disclose Protected Health Information to Authorized Facility

Patient's Legal Name ___________________________ **Date of Birth** ___________________

Previous Name ___________________________ **Phone Number** ___________________

Release From: Pain Centers of Minnesota
Address: 3000 Hundertmark Road, Suite 200
City: Chaska State: MN Zip Code: 55318
Phone: (763) 201-8191 Fax: (763) 201-8192

Release To: (Clinic or Organization) ___________________________

Address: ___________________________City: ___________________
State: ________ Zip Code: _________ Phone: ___________________ Fax: ___________________

- **For the Purpose of:**
  ☐ Continuing Care ☐ Insurance ☐ Worker's Compensation ☐ Legal ☐ Other (Specify)
- **This request and authorization applies to:**
  ☐ Healthcare information for continued care of treatment and/or condition: (check for all below)

☐ Demographics	☐ Lab Reports
☐ History and Physical	☐ Pathology Reports
☐ Discharge Summary	☐ X-ray, MRI, CT Films
☐ Clinic Notes	☐ EKG/ECHO Reports
☐ Emergency Room Report	☐ Electronic Medical Record Review
☐ Consultation Reports	☐ Other ___________________
☐ Hospital & Operative Reports	

- **Dates of Service:** ___________________________ (All dates, unless specified)

All sensitive information regarding Alcohol and/or Drug Abuse, Behavioral Health & HIV will be released unless you restrict by initialing below:

- Do Not release Alcohol and/or Drug Abuse information: _____
- Do Not release Behavioral Health information: ______
- Do Not release HIV (AIDS) related information: ______

I understand the following:

- Information in the chart that was not generated by Metropolitan Surgical Center will not be released to another facility. (We recommend that the original facility be contacted to obtain these records.)
- I understand that I can request, in writing, that the authorization be cancelled at any time.
- I understand that once Metropolitan Surgical Center has disclosed the health care information I have authorized, Metropolitan Surgical Center has no control over the information and that this information may no longer be protected by privacy laws.
- Metropolitan Surgical Center may not provide treatment to any patient that refuses to sign an authorization for release of Protected Health Information.
- This authorization will be valid for 1 year from the date of my signature, unless a date, event or condition is otherwise specified.
- A photocopy/fax of this authorization will be treated in the same way as an original.

___________________________ ___________________________
Patient Signature or Representative (If a Representative Signs, state the Relationship)

Printed Name: ___________________________ Date: ___________________

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED