METROPOLITAN SURGICAL CENTER

Metropolitan Surgical Center
9645 Grove Circle N, Suite 250
Maple Grove, MN 55369
P: 763.201.8191
F: 763.201.8192

James B. Parmele, MD
Jason S. Wolff, MD
Ronald B. Boeding, MD
Dustin R. Ward, MD
Rano M. Faltas, MD
Jonathan Hagedorn, MD

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

Patient's Legal Name _____ **Date of Birth** _____

Previous Name _____ **Phone Number** _____

Release From: Metropolitan Surgical Center
Address: 9645 Grove Circle North, Suite 250
City: Maple Grove State: MN Zip Code: 55369
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
  - ☐ History and Physical
  - ☐ Discharge Summary
  - ☐ Clinic Notes
  - ☐ Emergency Room Report
  - ☐ Consultation Reports
  - ☐ Hospital & Operative Reports
  - ☐ Lab Reports
  - ☐ Pathology Reports
  - ☐ X-ray, MRI, CT Films
  - ☐ EKG/ECHO Reports
  - ☐ Electronic Medical Record Review
  - ☐ Other _____
- **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