BRAINERD LAKES SURGERY CENTER

Consent to Release Medical Records

Patient Name (last, first, middle initial) DOB

Patient's Address City State Zip

Home Phone Work/Cell Phone

Release Information **To**:

Release Information **From**:

Please note that we can only release information generated at this facility. If additional information is required please contact the facility in which the service was rendered.

Please present valid Photo ID when picking up records. ID Verified by _____

Please choose one of the following:

Date of Service _____

All Dates of Service _____

Condition of Treatment or Type of Treatment (If unsure of specific date) _____

Information to be Released:

___Operative Report ___Anesthesia Record ___Implant Log ___Pathology Results ___H&P (generated at BLSC)

___EKG(generated at BLSC) ___Billing Statements Other _____

A fee may apply for records of more than 10 pages.

Reason for Release of Information:

___Continuation of Care ___Insurance Purposes ___Military ___Disability ___Attorney Other_____

All Information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by Initialing Below:

____Do Not Release Alcohol and/or Drug Abuse information

____Do Not Release Behavioral Health Information

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. A photocopy of this authorization will be treated in the same manner as an original. Further, I realize that the facility cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections.

Signature of Patient/Guardian/Legal Representative Relationship to Patient Date

Authorization Expiration Date or Event (If left blank, authorization will expire one year from signature)

13114 Isle Drive ▌ Baxter, MN 56425 ▌ 218-822-2400 direct ▌ 866-863-2400 toll free ▌ 218-822-2401 fax