MODERNI SPINE

ELEVATED PAIN TREATMENT

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION:	Patient Full Name (print):		DOB:
	Address (City, State, and Zip Code):		
	Phone Number:	Email Address:	

HEALTH INFORMATION RELEASED FROM:			
	☐ Name of Organization/Clinic:		Attn:
	Address (City, State, and Zip Code):		
	Phone Number:	Fax Number:	

HEALTH INFORMATION RELEASED TO:	Name of Organization/Clinic: Moderni Spine PLLC		Attn: Cynthia Konrath PA-C
	Address (City, State, and Zip Code): 3454 Co Rd 101 Minnetonka MN 55345		
	Phone Number: 651-440-0939	Fax Number: 651-237-8706	

HEALTH INFORMATION TO BE RELEASED:	☐ Specific Date/Year of Treatment________________________				
	☐ CD of Images	☐ Doctor Notes	☐ Therapy Notes	☐ Operative Report	☐ Surgery Chart
	☐ Injection Notes	☐ Lab Reports	☐ Radiology Reports	☐ EMG Report	☐ Billing Statement
	☐ Other________________________				
	The Following Requires Special Consent by Law and must specifically be requested in order for it to be released:				
	☐ Chemical Dependence Program		☐ Psychotherapy Notes		
DELIVERY METHOD:	☐ Paper/Mail	☐ Fax	☐ CD of images only (Mail)		
PURPOSE FOR RELEASE:	☐ Personal Use	☐ Continued Care	☐ Marketing (Sharing testimonial for Summit Orthopedics)		
	________________________				

I understand that by signing this form, I am requesting that the health information specified above be sent to Moderni Spine PLLC. I understand that I may revoke this request at any time in writing to either party, but this will not apply to records already released. No party shall be allowed to condition treatment based on my decision to release my medical records. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee if allowed by law.

________________________ ________________________ ____________

Print Name Signature Date

Authorized Person's authority to sign (proof required): ☐ Patient is a Minor ☐ Power of Attorney or Legal Representative ☐ Other________________

Released By:________________ Date:__________ MRN:__________ Physician:__________