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## AUTHORIZATION FOR RELEASE OF INFORMATION

You must complete every section below or this form may be returned to you for completion.

Please circle:	
<b>Patient Name:</b> _____	<b>RELEASE TO</b> or <b>OBTAIN FROM</b>
<b>Date of Birth:</b> _____	_____
<b>Address:</b> _____	_____
_____	_____
<b>Phone #:</b> _____	Fax # _____

### SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> X-Ray Reports  |
| <input type="checkbox"/> Pathology Reports   | <input type="checkbox"/> Lab Reports  | <input type="checkbox"/> Hospital Notes |
| <input type="checkbox"/> Billing Statements  | <input type="checkbox"/> Other _____  |   |

### TIMEFRAME

I would like records released from the following dates of service: \_\_\_\_\_ through \_\_\_\_\_.

### PURPOSE OF RELEASE OF INFORMATION

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Further Treatment (appt. date: _____) | <input type="checkbox"/> Payment of Insurance Claim | <input type="checkbox"/> Legal     |
| <input type="checkbox"/> Insurance Application                 | <input type="checkbox"/> Disability Determination   | <input type="checkbox"/> Education |
| <input type="checkbox"/> At request of patient                 | <input type="checkbox"/> Other: _____               |                                    |

I authorize the use and disclosure of my individually identifiable health information as described above, including written and verbal exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary and that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I also understand that the above records may contain information regarding STDs, HIV/AIDS, mental health, substance abuse or other sensitive information. This authorization will expire 12 months from date of signing or on \_\_\_/\_\_\_/\_\_\_, and includes information generated until that date. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized. I understand that my health care and payment for my health care will not be affected if I do not sign this form. A copy of this form is as effective as the original.

\_\_\_\_\_  
Signature of Patient/Guardian/ Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not patient, state authority/relationship

\_\_\_\_\_  
Reason patient unable to sign

For Office Use Only: \_\_\_\_\_

Copied / Printed / Faxed

Information Disclosed: Notes Labs Path X-ray Hospital Diagnostics

Initials \_\_\_\_\_ Date: \_\_\_\_\_

DOS: \_\_\_\_\_ to \_\_\_\_\_

Other \_\_\_\_\_