

**Authorization for Release
Medical Records and/or X-rays**

<input type="checkbox"/> 701 – 25 th Avenue South Suite 505 Minneapolis, MN 55454 Phone: (612) 455-2008 Fax: (612) 455-2045	<input type="checkbox"/> 6545 France Avenue South Suite 160 Edina, MN 55435 Phone: (952) 835-0750 Fax: (952) 835-0662
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- | | |
|--|---|
| <input type="checkbox"/> Owen R. O'Neill, M.D. | <input type="checkbox"/> Edward W. Kelly, M.D. |
| <input type="checkbox"/> Mark A. Heller, M.D. | <input type="checkbox"/> Paul R. Langer, D.P.M. |
| <input type="checkbox"/> Michael J. Nemanich, M.D. | <input type="checkbox"/> Clare K. McCarthy, M.D. |
| <input type="checkbox"/> Laurie D. Koch, M.D. | <input type="checkbox"/> Joseph P. Nemanich, M.D. |

Patient Name: _____ Birth date: _____

Address: _____

Social Security Number: _____ - _____ - _____

This form will authorize: Minnesota Orthopaedic Specialists, P.A.

- | | | |
|--|---|---|
| <input type="checkbox"/> 701 25 th Avenue South
Suite 505
Minneapolis, MN 55454 | <input type="checkbox"/> 6545 France Avenue South
Suite 160
Edina, MN 55435 | <input type="checkbox"/> 14000 Nicollet Avenue South
Suite 102
Burnsville, MN 55337 |
|--|---|---|

To release my medical records to:

(Name)

(Street)

(City, State and Zip)

I request the following information to be sent:

_____ Complete Medical Records

_____ Radiology Films

The following limitations shall be observed with respect to the type of information to be released:

***Purpose of information release: _____

I understand that I may revoke this consent at any time and that upon fulfillment of the above state purpose(s), this consent will automatically expire without my express revocation. Any copy of this authorization shall have the same authority as the original.

Signature of Patient

Date (must be filled in)