TWIN CITIES ORTHOPEDICS

Minnesota Orthopaedic Specialists

Authorization for Release
Medical Records and/or X-rays

☐ 701 – 25th Avenue South Suite 505 Minneapolis, MN 55454 Phone: (612) 455-2008 Fax: (612) 455-2009	☐ 6545 France Avenue South Suite 160 Edina, MN 55435 Phone: (952) 835-0750 Fax: (952) 835-0662

- ☐ Owen R. O'Neill, M.D.
- ☐ Mark A. Heller, M.D.
- ☐ Michael J. Nemanich, M.D.
- ☐ Laurie D. Koch, M.D.
- ☐ Edward W. Kelly, M.D.
- ☐ Paul R. Langer, D.P.M.
- ☐ Clare K. McCarthy, M.D.
- ☐ Joseph P. Nemanich, M.D.

Patient Name: ____ Birth date: ______________________

Address: ____

Social Security Number: ______ -____- ______

This form will authorize:

____
(Name)

____
(Street)

____
(City, State and Zip)

To release my medical records to: **Minnesota Orthopaedic Specialists, P.A.**

☐ 701 25th Avenue South
Suite 505
Minneapolis, MN 55454

☐ 6545 France Avenue South
Suite 160
Edina, MN 55435

☐ 14000 Nicollet Avenue South
Suite 102
Burnsville, MN 55337

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)