METROPOLITAN NEUROSURGERY, PA
11850 Blackfoot St NW
Suite 490
Coon Rapids, MN 55433
763-427-1137 (Phone)
763-427-4643 (Fax)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION (Please print)

Name ____ DOB: __________SS# __________
First **Middle** **Last**

Home #_________________ Work # __________________ Cell # ____________________

PROVIDER (Who is releasing Information?)

Name: ____

Address: ____
Street **City** **State** **Zip**
Phone # ____________________________ Fax #___________________________

REQUESTER (Where do you want this information to be sent?)

Name: ____

Address: ____
Street **City** **State** **Zip**
Phone # ____________________________ Fax #___________________________

PURPOSE OF RELEASE

☐ Relocation ☐ Insurance ☐ Legal ☐ Personal ☐ Continuing Medical Care ☐ Other (Specify)

INFORMATION REQUESTED

☐ Consultation Reports ☐ Operative Reports ☐ Progress Notes ☐ ALL ☐ Other (Specify)

This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

**For imaging records (reports and/or images), please contact the facility where the imaging took place.

Signature: ____
(legal representative if patient is under 18)

Today's Date: ___________________________________

Relationship to Patient (if applicable): ____________________