CHASKA PLAZA SURGERY CENTER
DBA TWO TWELVE SURGERY CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
PLEASE PRINT OR TYPE

PATIENT NAME_____BIRTH DATE_____

STREET_____

CITY_____STATE_____ZIP CODE_____

TELEPHONE:
HOME_____WORK_____MOBILE_____

I hereby request and authorize:_____
Facility name and complete address

To release copies of my medical records to:_____
Facility name and complete address

TYPE OF INFORMATION TO BE DISCLOSED:

Records:_____Films_____

Approximate date of treatment:_____

The information is needed for the following purpose:
__Insurance
__Legal (must be requested by attorney)
__Medical Care
__Personal Use
__Other:_____

I understand that I may revoke this consent at any time, and that this authorization will automatically expire 12 months from the date of my signature. I understand that once information is released pursuant to this authorization, CPSC cannot prevent the disclosure of the information to another third party. CPSC will not condition treatment on my signing this authorization. I understand there may be a retrieval and copy charge associated with the release.

Patient's signature_____Date_____
(Signature and date must be in ink)

Spouse, Parent or Guardian
authorizing release_____Date_____

If someone other than the patient is signing, state the relationship to the patient and reason the patient cannot sign:_____

Medical Records Released by_____Date_____