Advanced Surgical Associates
OF NORTHERN MINNESOTA

Medical Record Release Authorization Form

Patient Name: _____

Address: _____

City: _____ *State:* _____ *Zip Code:* _____

DOB: _____ *Phone #:* _____

I authorize Advanced Surgical Associates of Northern Minnesota to release my medical records to:

_____.

Please select the information you would like to release:

- ☐ *All records*
- ☐ *Operative notes*
- ☐ *Visit notes*
- ☐ *Billing information*
- ☐ *Pathology results*

- ☐ *Other:* _____

I understand that my records may contain restricted mental health information, communicable disease (HIV, AIDS, etc.), alcohol/drug abuse information. I do not want this information disclosed: _____

Please send selected records to:

_____

_____

_____

Signature of Patient or Legal Representative : _____

Date: _____ *If not Patient: Parent*: _____ *Guardian:* _____ *POA:* _____

4325 9th Ave West, Hibbing, MN
Phone: 218-461-6240 • Fax: 833-992-2182
mnsurgery.com

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This authorization will expire upon completion of this request. I understand that I have the right to revoke this authorization before it's completion.

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