ST. CLOUD
FOOT & ANKLE
CENTER

Release of Medical Records Authorization

PATIENT NAME:	**DOB:**
PHONE NUMBER:	**ADDRESS:**
DATES OF INFORMATION TO BE RELEASED FROM: __________ OFFICE NOTES __________ X-RAYS REPORTS/PRINTED IMAGINES __________ SURGERY REPORTS __________ MRI REPORTS (Ordered by our doctors)	**REASON FOR DISCLOSURE:** __________ **CONTINUING CARE** __________ **2ND OPINION** __________ **PERSONAL USE** __________ **ATTORNEY** __________ **OTHER (SPECIFY)**
SEND INFORMATION TO (PLEASE INCLUDE COMPLETE ADDRESS) NAME:______________________________ ADDRESS:______________________________ ______________________________ CITY:______________________________ STATE:__________________ ZIP:______________ FAX NUMBER:______________________________	**APPOINTMENT DATE** (IF APPLICABLE): ______________________________

I AUTHORIZE THE ABOVE PROVIDER TO RELEASE INFORMATION TO THE REQUESTER. A COPY OF THESE RECORDS WILL BE KEPT ON FILE.

______________________________	______________________________	______________
PATIENT/GUARDIAN SIGNATURE	RELATIONSHIP TP PATIENT	DATE

PLEASE ALLOW 5 BUSINESS DAYS TO PROCESS

106 Doctor's Park
St. Cloud, MN 56303
Fax: 320-656-9590