



NORTHWESTERN  
HEALTH SCIENCES  
UNIVERSITY

**Authorization for Release of Medical Information**

<b>Patient:</b>	Name: _____ Home Phone: _____ Previous name under which chart may be listed: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Social Security # _____ Date of Birth: _____ Age: _____ Treating Doctor's Name: _____
<b>Health Care Provider:</b>	<b>Who has information you would like released? "Please fill out completely"</b> University Health Services NORTHWESTERN HEALTH SCIENCES UNIVERSITY (NWHSU) 2501 W. 84 <sup>th</sup> Street Bloomington, MN 55431 Ph: (952) 885-5415 Fax: (952) 886-7590
<b>Requested By:</b>	<b>To Whom should the information be sent? "Please fill out completely"</b> Name: _____ Day Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
<b>Information to be released:</b>	<b>Please select (X) all the choices that apply:</b> ___ Complete X-ray films (including written results of MRI, CT, etc.) ___ Complete Medical Records (including Lab and X-ray reports, Patient Education Information, etc.) ___ Other (Specify) Records included will be for the last 24 months unless otherwise specified
<b>Reason for Release:</b>	<input type="checkbox"/> Insurance Change <input type="checkbox"/> Second Opinion <input type="checkbox"/> Move <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> Other _____
<b>Disclosure Statements:</b>	I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that signing this authorization is voluntary. I understand that once information is disclosed by NWHSU that the disclosed documents may no longer be protected by privacy laws.
<b>Authorization:</b>	I authorize the above provider to release the information marked above to the requestor:  Patient Signature: _____ Date: _____ <p style="text-align: center;">If other than patient, state relationship and reason patient cannot sign.</p>