



NORTHWESTERN
HEALTH SCIENCES
UNIVERSITY

Authorization for Release of Medical Information

Patient:	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: _____
Health Care Provider:	Who has information you would like released? "Please fill out completely" Bloomington Natural Care Center NORTHWESTERN HEALTH SCIENCES UNIVERSITY (NWHSU) 2501 W. 84 th Street Bloomington, MN 55431 Ph: (952) 885-5444 Fax: (952) 886-7561
Requested By:	To Whom should the information be sent? "Please fill out completely" Name: _____ Day Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Information to be released:	Please select (X) all the choices that apply: ___ 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
Reason for Release:	<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 _____
Disclosure Statements:	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.
Authorization:	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>