Itasca Surgical Clinic P.A.

1542 Golf Course Road, Suite 202 • Grand Rapids, MN 55744 • (218) 327-7973 • Fax (218) 327-3245
Daniel J. Margo, M.D. • General, Vascular, Laparoscopic Surgery and Endoscopy

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. PATIENT'S NAME: _____
   Last (Maiden) First Middle Date of Birth
2. ADDRESS: _____
   _____

3. I authorize: _____
   Person(s) or Organization(s)
   _____
   Address
   to give the right to examine, release, furnish copies of my medical records to Itasca Surgical Clinic.

4. The information released by this authorization should be limited to the following condition:_____
   from _____ to _____.
   _____
   _____

5. I am requesting this information be released for the following purpose:
   ☐ Continued Care by Another Provider ☐ Insurance Claim Purposes ☐ Other: _____
   ☐ Personal Use ☐ Attorney Review

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here:_____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or _____ (period of time) from the date of my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.
- I understand that once information is released pursuant to this authorization, Itasca Surgical Clinic cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
- Except for research-related treatment, Itasca Surgical Clinic will not condition treatment on my signing this authorization.

6. _____ _____ _____
   Signature of patient/authorized person | Authorized person's authority to sign (parent, guardian, power of attorney, etc.) | Date