Edina Sports Family Medicine

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Patient Name (please print): _____ Date of Birth: _____

Former Name (if any): _____ Telephone #: _____

RELEASE INFORMATION FROM:

_____
Organization

_____
Address

_____
City, State, Zip

RELEASE INFORMATION TO:

_____
Organization

_____
Address

_____
City, State, Zip

Purpose or Need for Information:

_____

_____

I hereby authorize the above party to release the following medical information for:

- ❑ Dates from: _____ to: _____
- ❑ Last date seen: _____
- ❑ Release all records.
- ❑ Release specific records: _____

This authorization will remain in effect a maximum of one year from the date of the signature and may be cancelled by me in writing at any time. A photocopy of this authorization will be treated in the same manner as the original. Patient is aware that the information disclosed may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date