MINNESOTA BONE AND JOINT SPECIALISTS

JEFFREY NIPPER, M.D. • JACK BERT, M.D. • JOE BOCKLAGE, M.D.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: __________

Previous Name: ____________________ Social Security: __________

I request and authorize ______________________________ to release healthcare information of the patient named above to:

Name: MN Bone & Joint Specialists

Address: 9325 Upland Lane N, Suite 205

City: Maple Grove State: MN Zip Code: 55369

Phone: 763-416-0777 Fax: 763-416-0476

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________________

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☐ All healthcare information

☐ Imaging (XRY/MRI/CT/US/EMG) including reports

☐ Other: ______________________________

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Name ____________________ Date: ____________________

Patient/Guardian Signature____

Relationship to Patient____