PHYSICIANS' DIAGNOSTICS & REHABILITATION
AUTHORIZATION FOR RELEASE OF INFORMATION

<table>
<tr><td rowspan="3">1
Patient Information</td><td colspan="3">Patient name:</td><td>Previous last name (if any):</td></tr>
<tr><td colspan="3">Street address:</td><td>Date of birth:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>Patient Phone:</td></tr>
<tr><td rowspan="4">2
Who has the information you want released?</td><td colspan="3">Organization Name:</td><td>Phone #:</td></tr>
<tr><td colspan="3">Provider Name:</td><td>Fax #:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td>City:</td><td colspan="2">State:</td><td>Zip:</td></tr>
<tr><td rowspan="3">3
To whom should the information be released?</td><td colspan="3">Facility/Provider/Insurance Company/Attorney/Patient name</td><td>Attention to:</td></tr>
<tr><td colspan="3">Address:</td><td>Phone #:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>Fax #</td></tr>
<tr><td>4
Information to be Released</td><td colspan="4">☐ Any and all records
☐ Clinic Visit Notes
☐ Rehab records (PT/OT)
☐ Radiology Imaging Reports
☐ X-Rays Date(s)/Details ______________________________
☐ MRI Date(s)/Details ______________________________
☐ CT Date(s)/Details ______________________________
☐ Ultrasound Date(s)/Details ______________________________
☐ Billing Records
☐Surgical Notes
☐ Other (specify) ______________________________
____
OPTIONAL LIMITS - Disclose only records related to the following:
Date(s) of service: ______________________________</td></tr>
<tr><td>5
Purpose of Release</td><td colspan="4">☐ Continuing Care ☐ Litigation/Legal*
☐ Transfer of Care ☐ Social Security Appeal
☐ Personal Use or Review* ☐ Social Security Disability determination*
☐ Insurance Application* ☐ Insurance payment/claim*
☐ Other* ______________________________
*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524</td></tr>
<tr><td rowspan="3">5
Authorization and Revocation</td><td colspan="4">• I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in section 3.
• I understand that this authorization will be valid for 12 months from the date signed to release any records created up to the date of signature. Any records created after the date of this authorization will require a new authorization. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2.
• If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information.
• I understand that when the health information specified in section 4 is sent to the third party named in section 3, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
• I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form.
• If I choose not to sign this form and the organization named in section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.</td></tr>
<tr><td colspan="3">Patient Signature:</td><td>Date</td></tr>
<tr><td colspan="4">If other than patient, state relationship and reason patient unable to sign</td></tr>
</table>