1230 East Main Street
Mankato, MN 56002-8674
Phone 507.625.1811 Fax 507.388.1878

Authorization to Release and Disclose Patient Information

MR#:

<table>
<tr><td rowspan="4">Patient</td><td colspan="2">Name:</td><td>Day Phone#</td></tr>
<tr><td colspan="2">Address:</td><td>Other Phone#</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2"></td></tr>
<tr><td>Health Care Facility / Provider</td><td colspan="3">WHO HAS INFORMATION YOU WOULD LIKE RELEASED?
Name:________________ Location: ________________
Address: ________________ Fax #: ________________
City: ________________ State: _______ Zip: ____________</td></tr>
<tr><td>Requestor</td><td colspan="3">TO WHOM SHOULD THE INFORMATION BE RELEASED?
Name: Mankato Clinic Appt. Date: ASAP - Please
Address: 1230 East Main Fax #: 507-385-4180
City: Mankato State: MN Zip: 56001-8684</td></tr>
<tr><td>Information to be disclosed</td><td colspan="3">MEDICAL RECORD RELEASE:
Records concerning: Ongoing authorization - All records from past 3 years seen; Procedure reports for Colonoscopies and Flexible Sigmoidoscopies in the past 10 years
Specific Diagnosis or Treatment and Specific Dates of Service
☒ Clinic notes / procedures ☒ Hospital notes /procedures ☐ HIV/AIDS records
☒ X-ray reports ☐ Financial / Billing ☒ Mental health notes
☐ X-Ray film / CD / other ☒ Echo / EKG reports / CD
☒ Lab / Pathology Reports Communication (check one / both) ☒ Verbal ☒ Written
☐ Pathology Slides ☐ Other: ________________</td></tr>
<tr><td>Reason for the Release</td><td colspan="3">☐ Insurance Change ☐ Out of Town Move
☐ Consult/Second Opinion ☒ Continuation of Medical Care
☐ Insurance Claim Report ☐ Legal
☐ Personal ☐ Other (specify): ________________</td></tr>
<tr><td>Revocation</td><td colspan="3">I understand that this authorization will be in effect for 12 months from the date signed unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing. A photocopy of this authorization will be treated in the same manner as original.</td></tr>
<tr><td>Authorization</td><td colspan="3">I understand that Mankato Clinic will not condition my treatment on whether I sign this authorization form, except in the following situations: (1) if treatment is related to research (such as a clinical trial), and the information will be disclosed as part of that research; or (2) if the purpose of the treatment is so that information can be disclosed to a third party (such as to an employer for a fitness-for-work examination). I understand that once information is released pursuant to this authorization, Mankato Clinic cannot prevent the re-disclosure of the information to another third party. I understand there may be a charge associated with the Release of Information services rendered.

________________ ________________ __________
Signature of patient/legal representative* Legal representative's authority to sign Date
(parent, guardian, health care power of attorney, etc.)</td></tr>
</table>

* Authorized representative may be required to submit copies of legal documents supporting his/her authority to act on a patient's behalf

COPIES: GIVEN / MAILED / FAXED ON: ________________ / CALL WHEN READY / PICK UP: ________________