



**GREELEY CLINIC**  
 921 S Greeley St  
 Stillwater, MN 55082  
 651-439-1234  
 651-439-1547 Fax

**CURVE CREST CLINIC**  
 1500 Curve Crest Blvd  
 Stillwater, MN 55082  
 651-439-1234  
 651-275-8298 Fax

**SOMERSET CLINIC**  
 700 Rivard St  
 Somerset, WI 54025  
 1-800-877-1588  
 715-247-2070 Fax

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

<i>PATIENT IDENTIFICATION</i>	Name: _____		
	Address: _____ _____		
	Telephone: (     ) - _____		
	Date of Birth: _____ SMG Chart #: _____		
<i>PROVIDER</i> <i>[Who has the information you would like released?]</i>	Name: _____		
	Address: _____ _____		
<i>REQUESTOR</i> <i>[Where do you want the information sent?]</i>	Name: _____		
	Address: _____ _____		
<i>INFORMATION TO BE RELEASED</i>	Clinic Notes Immunizations All Records	Lab Results EKG Results Other [Please Specify]	X-Ray Results Pathology Results
<i>REASON FOR RELEASE</i>	Medical Treatment At My Request	Insurance	Legal/Attorney
<i>INFORMATION RESTRICTIONS</i> <i>[Do you want to limit this information to include only certain dates or conditions?]</i>	<i>Specify dates and/or medical conditions if applicable:</i>		
<ul style="list-style-type: none"> <li>▪ I authorize the PROVIDER to release the requested medical information to the REQUESTOR. All records pertaining to psychiatric/mental health, chemical dependency and/ or HIV/AIDS related illness/testing will be released as authorized unless I have limited this as noted in the INFORMATION RESTRICTIONS section above.</li> <li>▪ I understand that this release will automatically expire one year from the date of my signature and that I may revoke it at any time by notifying the provider in writing; the revocation will take effect when the provider receives my written notice. I understand that my revocation does not affect prior disclosures or actions made or taken in reliance on this authorization.</li> <li>▪ I understand that once the Provider has disclosed health care information that I have authorized to be disclosed, the Provider has no control over this information. The person or organization that I authorized to receive the information might re-disclose it. The information may no longer be protected by privacy laws.</li> <li>▪ I understand that Stillwater Medical Group will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.</li> <li>▪ I understand that there may be a retrieval and copy charge associated with this release.</li> </ul>			
Signature of Patient: _____		Date: _____	
Or: _____		Date: _____	
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorized Representative <i>Check relationship to patient</i>			