

## Authorization for Release of Medical Information

RE: \_\_\_\_\_

Birth date: \_\_\_\_\_

This will authorize \_\_\_\_\_ to release to:

**Rockford Chiropractic**  
**9000 Walnut Street**  
**Rockford, MN 55373**  
**Phone (763) 477-5720**  
**Fax ( 1-866-595-5649)**

Information from the medical file records maintained while I was a patient at your facility during Any and All Dates.

The information to be disclosed includes the following:

  
  
  
  

Discharge Summary  
Consultation Reports  
History & Physical Exams  
File Correspondence  
Daily Notes

  
  
  

Operative Reports  
Radiological Studies  
Complete Chart  
Psychiatric Chart

The information is needed for the following purposes: \_\_\_\_\_

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire without my express revocation. I do not authorize further release to any third part.

\_\_\_\_\_  
(Signature of Patient or Guardian)

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Relationship with patient)

Minnesota Statute 254A.09

\_\_\_\_\_  
(reason patient unable to sign)