1935 County Road B2, West
Suite 100
Roseville, MN
55113
651-636-4155 (phone)
651-636-3595 (fax)
www.rosenbergcenter.com

Authorization for Release of Information

Patient:	**Name**	**Previous Last Name (if any)**	
	Address	**Day Phone Number**	
	City	**State**	**Zip Code**
	Date of Birth	**Social Security Number**	
Who has the information you would like released?	**Name**	**Department**	**Phone Number**
	Address		
	City	**State**	**Zip**
To whom should the information be sent?	**Name** Rosenberg Center	**Appointment with:**	**Phone** 651-636-4155
	Address 1935 County Road B2 West, Suite 100		
	City Roseville	**State** MN	**Zip code** 55113

Information to be disclosed:
I need by:
_____
(Date)
I will pick up by:
_____
(Date)

Medical Record Release
Records concerning:

- ☐ Clinic visit notes
- ☐ Genetic Testing
- ☐ Mental Health Records
- ☐ X-Ray Reports
- ☐ Lab Reports
- ☐ Therapy Records
- ☐ Psychological Testing
- ☐ Chemical Dependency Records
- ☐ Other (specify)_____
- ☐ Consultation/Follow-up Reports

Reason for Release:

- ☐ Insurance change
- ☐ Disability
- ☐ Continuation of Medical Care
- ☐ Consult/second opinion
- ☐ Personal
- ☐ Insurance application
- ☐ Insurance claim report
- ☐ SSI appeal
- ☐ Legal
- ☐ Other (specify)_____
- ☐ Move

Revocation:
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.

Authorization:
I authorize the above provider to release the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon receipt, Rosenberg Center will use the information for continuing my medical care and may release the information to other providers involved in my care. I understand there may be a charge for my records per Minnesota Statute 144.335.

Patient Signature:_____Date:_____

If other than patient, please state relationship and reason patient cannot sign:
_____