AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____

_____

PATIENT: _____
(NAME: FIRST, MIDDLE, LAST/DOB)

RELEASE TO: WRIGHT COUNTY ATTORNEY'S OFFICE, BUFFALO, MN
ANNANDALE POLICE DEPARTMENT, ANNANDALE, MN

I request information and authorize the above named doctor or health-care provider to release the information specified below to the organization, agency or individual named on this request.

Information requested:

1. Doctor's notes, statements and opinions.
2. Copy of history/physical, discharge summary and operative reports.
3. Copy of outpatient and ER admissions.
4. Copy of complete hospital chart.
5. Other
   (specify)_____

Dates Covered:

_____ All admissions or care at this facility or by its doctor.

_____ Limited to treatment dates and for conditions describe below:

From _____ to present_____

For treatment of injuries arising out of _____
On _____.
(date)

Purpose for which information is to be used: Criminal prosecution.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above-authorized information may not be accomplished without my further written consent. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Dated: _____ _____
(Parents Signature)