PAVILION

SURGERY CENTER

920 East First Street, Suite P101 Duluth, MN 55805

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ _____

Patient's First Name Middle Initial Last Date of Birth

_____

Street Address City State Zip Code

I hereby authorize **Pavilion Surgery Center**

Facility or individual releasing information

To release the following information to :

_____

Name of insurance company, health care facility, attorney, individual, etc.

_____

Street Address City State Zip Code

Specify Dates and/or Type of Treatment:_____

Information Requested: _____

_____

_____

Records are necessary for:

☐ Continuing Care ☐ Legal Purposes

☐ Payment of Claim ☐ Insurance Application

☐ Other (specify) _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken upon it. If not previously revoked, this consent will terminate within one year from the date on which it is signed Any further redisclosure of the medical information by recipient(s) is not authorized without the specific written consent of the Person to whom it pertains A photocopy of this authorization will be treated in the same manner as the original.

DO NOT SIGN UNLESS ALL SPACES ARE FILLED IN COMPLETELY.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient/Guardian if minor/Specify relationship Date

Phone: 218-279-6200 Fax: 218-279-6205