



AUTHORIZATION FOR RELEASE OF INFORMATION

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Patient Name _____

(Please Print) First /Middle / Last

Birth date _____ Social Security Number _____

Information released **from:**

Clinic Name _____

Provider Name _____

Address _____

City _____ State _____ Zip _____

Information released **to: (Fill in either address OR email)**

Name _____

Address _____

City _____ State _____ Zip _____

Email (where you would like the records emailed to):

Purpose of disclosure _____

Information to be disclosed:

- ALL** – Clinic visit notes, consultations/follow-up visits up to two years.
- Specific** single date(s) of service requested _____
- X-ray and lab reports
- Pathology reports
- Hospital-operative reports, consultations, ER visits and discharge summaries
- All of the above
- Other _____
- Pathology slides (specifically requested by reviewing physician)

Signature _____

Relationship/reason if other than patient _____

Date _____ (I understand that I may revoke this consent at any time and this authorization is valid for one year unless otherwise noted.)

*I understand that once information is released under this authorization, the clinic, employees and physicians cannot prevent disclosure of information.

“Information not originally generated by Metro Urology will not be released. Such information must be obtained from the original source.

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