NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
Coon Rapids, MN 55433
Ted Harrison DC, FACO

Patient Information	Name ______________________________ Date of Birth ______________________________ Address______________________________ City/State/Zip ______________________________ Phone______________________________
Releasing Healthcare Provider	North Suburban Healthcare, PA 8770 Springbrook Dr. NW Suite 100 Coon Rapids, MN 55433 Phone (763)754-2573 Fax (763)754-0128
Receiving Healthcare Provider(s) or Entity	Name ______________________________ Address/City ______________________________ Phone ______________________________
Information to be Released (Please indicate date range/event and what type of information)	Dates of Service _______________ to _______________ Or Incident ______________________________ ☐ Full Office Notes ☐ Radiology Reports ☐ Radiology Images ☐ Other: ______________________________
Purpose of Release	☐ Continuation of Care ☐ Transfer of Care ☐ Personal Use ☐ Legal ☐ Other ______________________________

This authorization is valid for one year from the date of signature unless otherwise indicated date or event here: ______________________________

I understand that this authorization can be cancelled in writing at any time by contacting North Suburban Healthcare, PA and the releasing health care provider.

I understand that North Suburban Healthcare, PA cannot prevent redisclosure of my information by an authorized receiving party.

Signature ______________________________ Date _______________

Relationship to patient (if not self): ______________________________