



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____

Patient Email: _____

INFORMATION TO BE RELEASED TO/FROM SAUNDERS THERAPY CENTERS, Inc:

- Bloomington:** 4801 West 81st Street, Suite 103 Bloomington, MN 55437
Phone: 952-924-0199 Fax: 952-924-0314
- St. Paul:** 755 Prior Avenue North, Suite 235E St. Paul, MN 55104
Phone: 651-645-8083 Fax: 651-645-8078
- Maple Grove:** 10900 73rd Avenue North, Suite 140 Maple Grove, MN 55369
Phone: 763-315-1296 Fax: 763-315-1297

INFORMATION TO BE RELEASED FROM/TO

Name: _____

Address: _____

Email: _____

Phone Number: _____ Fax: _____

Relationship to patient (Clinic, Attorney, Family, etc.): _____

INFORMATION TO BE RELEASED (check all that apply):

- All Medical records on file.
- Specific treatment dates: from: _____ to: _____
- Other (please provide specifics) _____

METHOD OF INFORMATION RELEASE (check all that apply):

- Mail to the address checked above.
- Fax to the number checked above.
- Verbally discuss with a therapist located at the address checked above.

Unless specified otherwise below, this authorization will remain in effect for 1 year from the date of signature.

This request expires on _____ (date)

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ Date: _____