SAUNDERS THERAPY CENTERS

# 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 **(circle one)** SAUNDERS THERAPY CENTERS, Inc:

☐ 4801 West 81st Street, Suite 103 Bloomington, MN 55437
Phone: 952-924-0199 Fax: 952-924-0314

☐ 755 Prior Avenue North, Suite 235E St. Paul, MN 55104
Phone: 651-645-8083 Fax: 651-645-8078

☐ 10900 73rd Avenue North, Suite 110 Maple Grove, MN 55369
Phone: 763-315-1296 Fax: 763-315-1297

**INFORMATION TO BE RELEASED** FROM/TO **(circle on**e):
Name:_____

Address:_____

Email: _____

Phone Number: _____

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:_____**