Northern Star Therapy Ltd.
Physical and Occupational Therapy

Authorization for Release of Protected Health/Medical Information to Patient or Guardian

_____ _____ _____
Print Patient Name | Social Security No. | Date of birth

I hereby authorize and request Northern Star Therapy, Ltd. to use and disclose individually identifiable health information prepared, received, and maintained by Northern Star Therapy, Ltd. in its medical record dedicated to the Patient Name identified above to the following entity or individual:

Release by Pick-up or Mail to:
(Circle delivery choice above)

_____
Name of Person, Clinic or Facility

_____
Street Address (if applicable)

_____
City, State, Zip code (if applicable)

Records for date of service: _____

Type of Information:

_____ Therapy Notes
_____ Other (please specify):
_____

This authorization relates to medical record information prepared, received, and maintained by the facility of the dates of service requested, and also includes records prepared, received, and maintained by the facility after the dates of signature for a period of one year. Furthermore, a photocopy of this signed authorization will be treated as a valid representation of the originally signed document.

This authorization will remain in effect for a period of one year from date of signature. However, I may revoke this authorization at any time, through a note that is signed, dated, and effectively presented to Northern Star Therapy, Ltd. pursuant to its Notice of Privacy Practices. I also understand that such revocation does not apply to any information already released, or obtained in good faith, by Northern Star Therapy, Ltd.

Furthermore, I understand that if the entity or person that I authorize to receive medical record information is not a provider or health plan, the release information could be re-disclosed and such disclosure may not be protected by federal privacy regulations. I understand that Northern Star Therapy, Ltd. will not condition its treatment of the Patient Name identified above on whether or not this form is signed unless as otherwise permitted by law or described in the Notice of Privacy Practices for Northern Star Therapy, Ltd.

*Note: Copy maintained in Medical Record; Patient or Auth. Rep. Entitled to Copy.

_____ _____
Signature of Patient or Authorized Representative | Date of Signature

_____
Auth. Rep. Relationship to Patient (if applicable)

THIS AUTHORIZATION MUST BE EFFECTIVELY SIGNED BEFORE RECORDS WILL BE RELEASED.
RELEASE OF RECORDS MAY BE SUBJECT TO A CHANGE PURSUANT TO MINNESOTA LAW

When Experience Matters!

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