Jenny Kendall, DO
PM&R physician,
Interventional Spine specialist,

INSTITUTE for
REGENERATIVE MEDICINE
HYPERCHARGE
HEALTH

Stepahnie Forstner, NP
Certified Nurse Practitioner

Louis C. Saeger, MD, FIPP, FACPM
Board Certified
Anesthesiology, Medicine,
Interventional Pain Management

Stefano M. Sinicropi, MD, FAAOS
Board Certified
Orthopedic Spine Surgeon

Angie Finn, NP
Certified Nurse Practitioner

Release of Medical Information from an Authorized Facility

First Name:	Middle Initial:	Last Name:	Maiden/Other:
Date of Birth:	Home Number:	Cell Number:	Other Contact:
Email Address:			
Street Address:		City State Zip Code:	

Please release my records:

From: Organization name: _____

Street Address:	City State Zip Code:
Phone Number:	Fax Number:

To: Institute for Regenerative Medicine by HyperCharge Health

Street Address: **7450 France Ave S. Suite 240**	City State Zip Code: **Edina, MN 55435**
Phone Number: **(952) 247-4785**	Fax Number: **(612) - 353 - 4065**

Records I would like to be released pertaining to my _____ **pain:**

- ☐ 3-6 most recent clinic notes
- ☐ Surgical Reports
- ☐ Procedure/Injection Notes
- ☐ Physical Therapy/Chiropractic
- ☐ Lab Results
- ☐ X-ray, MRI, CT, EMG

☐ Date records are needed: _____ or o **STAT: required for today's appointment.**

The Following Information requires special consent by law. This is not included with All Health Records; you must specifically request the following information for it to be released.

- ☐ Chemical Dependency program
- ☐ Psychotherapy notes
- ☐ AIDS/HIV

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that by signing this release I am not authorizing the parties in receipt of this information to further disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. However, I understand that this information may be subject to re-disclosure by the recipient and that it will no longer be protected by federal or state privacy laws. I understand that I may revoke this authorization at any time by giving written notification to the organization, but if I do, it won't have any effect on any actions that they took before they received the revocation. I understand that the Institute for Regenerative Medicine by HyperCharge Health of Minnesota will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent. If I choose not to sign this form and the organization named to have health information released to is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care which I may, therefore, be responsible for.

"This consent will end one year from the date the form is signed UNLESS an earlier date is indicated in writing"

Patient Signature: _____ Date: _____

Or Legal Authorized Representative's Signature: _____

Relationship to Patient: _____ Date: _____