



Between the Bridges Healing Center

Authorization to Release Medical Information

I authorize:

Name of Facility Sending Information

To release to:

Between The Bridges Healing Center
Jeff Kotulski, D.O.
45 Teton Lane
Mankato, MN 56001

The following information:

All information

All Progress Notes

Lab Reports

X-ray/MRI/CT

Immunization Records

Other _____

For the time period from: _____ to _____.

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. The requestor may be provided with a copy of this authorization.

PRINT PATIENT'S NAME _____ **DATE OF BIRTH** _____

PATIENT'S SIGNATURE _____ **TODAY'S DATE** _____

SPECIAL AUTHORIZATION: Check information to be included and sign below.

By signing below, I am authorizing the office to release any and all info regarding:

Alcohol Drugs Mental Health STDs HIV AIDS

PATIENT'S SIGNATURE _____ **TODAY'S DATE** _____