HENDRIX HEALTH CENTER
MSU Moorhead
Moorhead, MN 56563
(218) 477-2211

Name: ______________________
SSN: ______________________
GENDER: ___________________
DOB: ______________________

Phone: ______________________

MEDICAL AUTHORIZATION
TO OBTAIN HEALTH INFORMATION

TO: ___________________________________

____

____

I, _______________________________, hereby authorize the release of the following information to the **Hendrix Health Center, MSU Moorhead, Moorhead, MN 56563**. Fax number (218) 477-5867.
Please send the records to the attention of ____.

____ Initial evaluation
____ Progress notes
____ Consultation reports
____ Discharge/treatment summary
____ Diagnostic test results (specify) ____
____
____ Other ____

____ Entire medical records
____ History and physical
____ Psychological testing

I further authorize you to discuss the above noted information with ___________________________________ at Hendrix Health Center.

I understand that I sign this form voluntarily and that I may change my mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This consent form will expire 90 days following the date signed.

Signature ____ Date _________________

*The above consent is given on this patient's behalf because the patient is a minor ( ), or is unable to sign for the following reasons:

____

____ Date __________________
* Signature of Closest Relative or Legal Guardian (state relationship)