# Authorization for Release of Protected Health Information (ROI)

At Rejuv Medical, we are committed to providing patients with convenient and secure access to their health information. Many records are available for download through the Athena Patient Portal, where you can securely view and share your information with other providers. If you would like Rejuv Medical to release records on your behalf, please complete the authorization section below.

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|---|---|---|
| **Patient Information:** | Full Name: | Date of Birth: |
| | Address: | Contact#: |
| **Release Information FROM:** | Rejuv Medical | 901 3rd St N,<br>Waite Park, MN 56387<br>Phone: (320) 217-8480<br>Fax: (320) 217-8490 |
| **Release Information TO:** | Person / Business / Clinic / Hospital / Provider: | |
| **Release Information via:** | ☐ USPS Mail<br>☐ Email<br>☐ Fax | _____<br>_____<br>_____ |
| **Related to Body Part:** | ☐ All<br>☐ Specific body part: _____ | |
| **Appointment Type:** | ☐ All Records<br>☐ Orthopedic Records Only<br>☐ Functional Medicine Records Only | ☐ Physical Therapy Records Only<br>☐ Imaging Records Only |
| **Date of Service:** | ☐ All<br>☐ Specific Dates: _____ | |
| **Reason for Release:** | ☐ Personal Use<br>☐ Insurance<br>☐ Attorney / Legal | ☐ Continuation of Care<br>☐ Transfer / Termination of Care<br>☐ Other _____ |

Acknowledgment and Understanding

- I understand that this request pertains only to my own medical records, and that I am the patient associated with this request.
- I understand that the date range for this request when selecting all services is from April 15, 2025, to the present. For records outside of this date range, I understand that I must contact the o□ice directly and complete a separate paper authorization form.
- I understand that this authorization is valid for one (1) year from the date of my signature.
- I understand that I have the right to revoke this authorization at any time in writing. I acknowledge that such revocation will not apply to any actions already taken in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by this authorization.
- I understand that any information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected under federal or state privacy laws.
- I understand that if records are requested in printed format for pickup or delivery via USPS, a fee of $0.25 per page will be applied and charged to my patient account.
- I understand that requests for Protected Health Information are typically processed within 1 to 5 business days and will be completed within a maximum of 30 calendar days.

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| **Authorization** | Patient / Guardian Signature: | Date: |
| | Relationship to Patient: | |