VOLUNTARY AUTHORIZATION FOR RELEASE OF MEDICAL AND INSURANCE INFORMATION

I, ______________________________, date of birth: _______________, authorize
(print full name) (month, day, year)
____, to release and send all medical or
(name of company, clinic, physician, attorney or the custodian of records, agents, or their attorneys)

insurance information and records about me concerning ________________________________
(condition, diagnosis, treatment, incident, etc.)
to the Minnesota Attorney General's Office.

I am releasing this information to the Attorney General's Office, which may use it now and in the future in connection with the investigation, review and/or litigation of a complaint I filed with that Office either in its own capacity or by referral to other government agencies. I understand that the information provided to the Attorney General's Office may be shared with the parties I complained against. I understand that I am not legally required to provide this information, but that failure to do so may hinder efforts to resolve my problem.

I understand that copies of my record may be released to the Attorney General's Office before I have had an opportunity to either review either the records or others' evaluation of the records. I save and hold harmless those who comply with this release, and agree that the entity named above will not be held liable by me for releasing these records or revealing this information.

I give this written permission voluntarily. I retain the right to revoke this consent at any time within one year from the date of my signature, except to the extent any person or entity who makes a disclosure or reveals information under this authorization has already taken action and reliance on it.

I understand and agree that a photocopy of this signed authorization shall have the same force and effect of the original. This release is valid for one year.

If the data subject is a minor or deceased, I attest that I am authorized by law to sign on the minor or the decedent's behalf.

____
Name of subject/minor/decedent

____
Guardian or representative's relationship to subject

____
Address

____
Signature of subject/guardian, representative

____
Date