Business Office Permission to Release

Customer Name: _____ DOB: _____

Guarantor Number(s): _____

Address: _____

I understand that North Memorial Health includes North Memorial Health Hospital, North Memorial Health Primary and Specialty Care Clinics and Maple Grove Hospital. I give the North Memorial Health Business Office team members permission to discuss and/or provide a copy of my Business Office records for all billing items and my medical condition related to billing. If there are any items I do not want shared I am listing them here:

_____

_____

_____

To the following individuals:

Name, Relationship, Phone Number:

_____

Name, Relationship, Phone Number:

_____

Name, Relationship, Phone Number:

_____

I understand this authorization shall remain in effect unless I revoke it in writing to North Memorial Health Business Office, 3300 Oakdale Ave. Robbinsdale, MN 55422.

Signature of Customer/Legal Guardian _____

Date: _____

Fax completed form to North Memorial Health Business Office at **(763) 581-4501** or mail it to: **Central Business Office, 3300 Oakdale Ave. Robbinsdale, MN 55422.**