



Health Information Management
 3800 Park Nicollet Blvd.
 St. Louis Park, MN 55416-2699
 952-993-7600 tel 952-993-1811 fax

Radiology Film Library
 3930 Louisiana Circle
 St. Louis Park, MN 55426
 952-993-5427 tel 952-993-1718 fax

Authorization for Release of Information



113720AUTHC

NAME: For Office Use Only:

DOB:

MR#:

HCL# :

LABEL or ADDRESSOGRAPH

| | | | | | |
|---|--|--|-----------------------------|---------------|-------------|
| Patient: | Name | | Previous Last Name (if any) | | |
| | Address | | | Day Phone No. | |
| | City | | State | | Zip |
| | Date of Birth | | Social Security Number | | XXX-XX-____ |
| Who has the information you would like released? | Name | | Dept | | Phone No. |
| | Address | | | | |
| | City | | State | | Zip |
| To whom should the information be sent? | Name | | Dept | | Phone No. |
| | Address | | | | |
| | City | | State | | Zip |
| Information to be disclosed: I need by: Date _____ I will pick up by: Date _____ | MEDICAL RECORD RELEASE | | | | |
| | Records Concerning: _____ <small>Specific Diagnosis or Treatment and Specific Dates of Service</small> <input type="checkbox"/> Clinic visit notes <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Mental Health Records <input type="checkbox"/> X-ray Reports <input type="checkbox"/> Pathology Slides <input type="checkbox"/> Chemical Dependency Records <input type="checkbox"/> Lab Reports <input type="checkbox"/> HIV or AIDS Records <input type="checkbox"/> Immunizations <input type="checkbox"/> Consultation/Follow-up Reports <input type="checkbox"/> Non-Park Nicollet Health Services Records <input type="checkbox"/> Other (Specify) _____ | | | | |
| Radiology Film Release: | * Call Radiology at 952-993-5427 to arrange release of images. <input type="checkbox"/> Original X-Ray of* _____ * Original film is loaned for 30 days. _____ <input type="checkbox"/> Mailed date _____ <input type="checkbox"/> X-Ray copies of _____ <input type="checkbox"/> Pick up date _____ | | | | |
| Reason for the Release: | <input type="checkbox"/> Insurance Change <input type="checkbox"/> Disability <input type="checkbox"/> Continuation of Medical Care <input type="checkbox"/> Consult/Second Opinion <input type="checkbox"/> Insurance Application <input type="checkbox"/> SSI Appeal <input type="checkbox"/> Insurance Claim Report <input type="checkbox"/> Legal <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Personal <input type="checkbox"/> Out of Town Move (send 2 years) _____ | | | | |
| Revocation: | I understand that this authorization will be in effect for 12 months from the date signed unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing. | | | | |
| Authorization: | I authorize the above provider to release the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon receipt, Park Nicollet Health Services will use the information for my continuing medical care and may release the information to other providers involved in the care. I understand there may be a charge for my records per Minnesota Statute 144.335. | | | | |
| | Patient Signature | | | | Date |
| | If other than patient, please state relationship and reason patient cannot sign: | | | | |