



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



111788AUTHC

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 Park Nicollet Health Services	Dept	Phone No. 952-993-7600
	Address 3800 Park Nicollet Blvd.		
	City St. Louis Park	State MN	Zip 55416
To whom should the information be sent?	Name	Dept	Phone No.
	Address		
	City	State	Zip
Information to be disclosed:	MEDICAL RECORD RELEASE		
	Records Concerning: _____ <small>Specific Diagnosis or Treatment and Specific Dates of Service</small>		
I need by:	<input type="checkbox"/> Clinic visit notes	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Mental Health Records
Date	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Pathology Slides	<input type="checkbox"/> Chemical Dependency Records
I will pick up by:	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> HIV or AIDS Records	<input type="checkbox"/> Immunizations
Date	<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"/> X-Ray copies of _____
	<input type="checkbox"/> Mailed date _____	<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 Park Nicollet Health Services 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 release, this health information is no longer protected by Park Nicollet Health Services and has the potential to be redisclosed by the recipient. 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:		