

Non-Park Nicollet Records

| Eor | Office | Hee | Only |
|-----|--------|-----|--------|
| FUI | Office | USE | Office |

| Authorizat | on for Rel | ease Nam | ne | | |
|--|--|---|--------------------------|---|---|
| rk Nicollet of Information | tion | DOE | 3 | | |
| | | MR# | ‡ | | |
| 35AUTHR nplete this form and send it to the pr | ovider and facili | ty listed in aues | tion #2 below. | | |
| | | | | Previous last | |
| Patient name | | | | name (if any)_ | |
| Date of birth | _ Phone # | | | | |
| Street address | | City | | State | ZIP code |
| | | | | | |
| Where are the records coming from? | 1 | E 10 | | | |
| Provider name | | Facility name | | | Phone # |
| Street address | | City | | State | 7IP code |
| 1001699 | | Oily | | | ∠II 600E |
| Where should the records be sent? (| select a, b, c or | d) | | | |
| a 🗌 Health Information Managemen | t—Park Nicollet N | Methodist Hospita | I; PO Box 650, Min | neapolis, MN 55440; | 952-993-7600 tel |
| b ☐ Health Information Managemen | t—Park Nicollet C | Clinic; 3800 Park I | Nicollet Blvd., St. L | ouis Park, MN 55416 | ; 952-993-7600 tel |
| Provider | | Facility | | | F # 050 000 |
| name | | name | | | Fax # 952-993 |
| Street address | | City | | State | ZIP code |
| Records concerning/Special instructi Dates requested: From / | | | | | |
| • | _ | | | | |
| What type of records should be releat (select any) | | | | in digital format (CD). | 6b Mammography Imaging Release |
| ☐ Clinic visit notes | | General X-rays | , , | | ☐ 30 day loan |
| Mental health records | | MRI | | | Permanent transf |
| Chemical dependency | | CT | | | ☐ Include radiology |
| ☐ Radiology reports | | Ultrasound | | | report(s) |
| Lab reports Radiation therapy | | Pet scan | | | 7 Pathology |
| ☐ HIV or AIDS records | | Include radiology | | | ☐ Pathology slides |
| ☐ Pathology reports | | molado radiologi | 100011(0) | | _ r amonogy ondoo |
| ☐ Non-Park Nicollet records | | | | | |
| Other (specify) | | | | | |
| Purpose for Release | | | | | |
| · | surance change | \square Disability | ☐ Legal* | | * Pre-pay charges app |
| <u> </u> | surance* | ☐ Personal* | | | for radiology images |
| Authorization and Revocation | | | | | |
| authorize the above provider to release the | information marked | above. I understand | I need not sign this for | m in order to assure treat | ment or payment. I understand |
| hat upon receipt, Park Nicollet Health Services v | vill use the information | n for my continuing m | edical care and may rel | ease the information to ot | her providers involved in the car |
| understand that when the health information for hat receives it and may no longer be protected | wnich i am authorizir by federal or state pri | ig release is sent to th vacy laws. I underst a | ie uiird party named ab | love, the information could large for my records per | i be re-disclosed by the third par • Minnesota Statute 144.292. |
| Revocation: I understand that this authorization areated after the date of this authorization will re | will be valid for 12 m | onths from the date s | signed to release any re | ecords created up to the d | late of signature. Any records |
| Park Nicollet Release of Information, and that th | e cancellation will tak | auon. i unutisianu ini a affact whan Park N | icollet Release of Infor | mation receives my writte | n notice |

Patient

Date_ 18535 (1/2012)