Park Nicollet

Authorization for Release of Information

Instructions

1. Please review and complete all sections of the form. Call 952-993-7600 with any questions.
2. If Patient: sign and date form before submitting.
3. If signing for Patient: sign, date and indicate relationship to patient before submitting.

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Patient

Patient name | Previous last name (if any)

Street address | Date of birth

City | State | ZIP code | Phone #

Information to be released *(select any)*

Medical records

☐ Clinic visit notes ☐ Mental health records ☐ Chemical dependency
☐ Radiology reports ☐ Lab reports ☐ Radiation therapy
☐ HIV or AIDS records ☐ Pathology reports ☐ Hospital
☐ Other (specify) (e.g., non-Park Nicollet records) _____

Records concerning/Dates requested/Special instructions

Radiology image release *(in most cases you will receive your images in digital format (CD)*

☐ General X-rays Date(s) _____
☐ MRI Date(s) _____
☐ CT Date(s) _____
☐ Ultrasound Date(s) _____
☐ Nuclear medicine Date(s) _____
☐ Pet scan Date(s) _____
☐ Include radiology report(s)

Mammography imaging release

☐ 30 day loan ☐ Permanent transfer ☐ Include radiology report(s)

Pathology

☐ Pathology slides

Purpose for release

☐ Continuation of care—Radiology
☐ Continuation of care—Medical Records *(6 visits or 6 months)*
☐ Insurance change
☐ Insurance*
☐ Out of town move *(send 2 yrs)*
☐ Disability
☐ Personal*
☐ Legal*
☐ Other _____

* *Pre-pay charges apply for radiology images*

To whom should the information be released?

To whom should the information be released? *(e.g., provider, insurance company, attorney, patient)* —**This section must be completed**

Radiology Image Release: Pre-pay charges apply for images released to patient without provider/facility information

Facility/Provider/Insurance company/Attorney/Patient name | Phone #

Street address | City | State | ZIP code

Method of delivery

Select one option for each type of record, if applicable.
Picture ID is required when picking up records. Written permission is required if someone other than patient is picking up information.

Medical records

☐ On paper ▶ ☐ Mail before (appointment date) ____ /____ /____ ☐ I will pick up on (date) ____ /____ /____

☐ Via secure email *(requires internet access)* ▶ Patient email address _____

Billing records

Statement date(s) ____ /____ /____ – ____ /____ /____ ▶ ☐ On paper ☐ On CD *(requires PDF Reader software)*

☐ Send via US Mail ☐ I will pick up on (date) ____ /____ /____

Authorization and Revocation

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 re-disclosed by the recipient. **I understand there may be a charge for my records per Minnesota Statute 144.292.**

Revocation: I understand that this authorization will be valid for 12 months from the date signed to release any records created up to the date of signature. Any records created after the date of this authorization will require a new authorization. I understand that I may cancel this authorization, by sending a written request for cancellation to Park Nicollet Release of Information, and that the cancellation will take effect when Park Nicollet Release of Information receives my written notice.

Please review the information you have entered above. If you are satisfied with your entries, click the PRINT button below, sign and submit this form. If you need to make changes, click the CLEAR button and begin again. Thank you.

Mailing instructions

Mail completed authorization to:
Release of Information
Park Nicollet Health Services
3800 Park Nicollet Blvd., St. Louis Park, MN 55416
952-993-7600 tel / 952-993-1811 fax

For radiology images *only*, mail authorization to:
Central Film Library
Park Nicollet Imaging Services
3930 Louisiana Circle, St. Louis Park, MN 55426
952-993-5427 tel / 952-993-1718 fax

Emergent after hours (5 pm - 6 am) requests *(health care facilities only)*:
Fax completed form to
952-993-6496

Print Clear