Park Nicollet

Non-Park Nicollet Records Authorization for Release of Information

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By completing and signing this form you are authorizing Park Nicollet Health Services to request information from the provider below.

NAME:

Instructions

1. Please review and complete all pertinent sections of the form. Call 952-993-7600 with any questions.

DOB:

MR#:

HCL# :

LABEL

Patient Name	Previous Last Name (if any)	Date of Birth	Phone #
Street Address	City	State	ZIP Code

From: Provider/Facility

Provider Name	Facility Name		Phone #
Street Address	City	State	ZIP Code

To: Park Nicollet Health Services—Select the option below where you would like your information sent

☐ **OPTION 1—choose hospital or clinic medical records**

☐ Health Information Management
Park Nicollet Methodist Hospital
PO Box 650
Minneapolis, MN 55440
952-993-7600 tel

OR

☐ Health Information Management
Park Nicollet Clinic
3800 Park Nicollet Blvd.
St. Louis Park, MN 55416
952-993-7600 tel

☐ **OPTION 2—direct to provider**

Provider Name		Facility Name
Fax # 952-993- _____	Street Address	
City	State	ZIP Code

☐ **OPTION 3—pick up in person**

I will pick up by (date) _____ / _____ / _____

Medical Record Release

Records Concerning/Dates Requested

- ☐ Clinic visit notes
- ☐ Mental health records
- ☐ Chemical dependency
- ☐ Radiology reports
- ☐ Non-Park Nicollet records
- ☐ Lab reports
- ☐ Radiation therapy
- ☐ HIV or AIDS records
- ☐ Pathology slides
- ☐ Other (specify)

Radiology Image Release

- ☐ 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)

Purpose for Release

- ☐ Continuation of care
- ☐ Insurance change
- ☐ Insurance
- ☐ Out of town move (send 2 years)
- ☐ Disability
- ☐ Personal
- ☐ Legal
- ☐ Other (specify)

Special Instructions

Authorization and Revocation

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 that when the health information for which I am authorizing release is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. **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.

Patient Signature

If other than patient, state r

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 below and begin again. Thank you.