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

FAX# 952-993-1811

For Office Use Only:

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:

Name | Previous Last Name (if any)
Address | Day Phone No.
City | State | Zip
Date of Birth | Social Security Number

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:

I need by: ____________
Date

I will pick up by: ____________
Date

MEDICAL RECORD RELEASE

Records Concerning: ____________
Specific Diagnosis or Treatment and Specific Dates of Service

- ☐ Clinic visit notes
- ☐ X-ray Reports
- ☐ Lab Reports
- ☐ Consultation/Follow-up Reports
- ☐ Radiation Therapy
- ☐ Pathology Slides
- ☐ HIV or AIDS Records
- ☐ Non-Park Nicollet Health Services Records
- ☐ Mental Health Records
- ☐ Chemical Dependency Records
- ☐ Other (Specify) ____________

RADIOLOGY FILM RELEASE

- ☐ Original X-Ray of* ____________
- ☐ X-Ray copies of ____________
- ☐ Mailed date
- ☐ Pick up date ____________

By ____________

* Return loaned films within 30 days

Reason for the Release:

- ☐ Insurance Change
- ☐ Consult/Second Opinion
- ☐ Insurance Claim Report
- ☐ Personal
- ☐ Disability
- ☐ Insurance Application
- ☐ Legal
- ☐ Out of Town Move (send 2 years)
- ☐ Continuation of Medical Care
- ☐ SSI Appeal
- ☐ Other (Specify) ____________

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: