Park Nicollet

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	
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 **EXAMONE/APS**	Dept	Phone No.
	Address **800 NW CHIPMAN RD, SUITE 5900**		
	City **P.O. BOX 2340 LEES SUMMIT, MO 64063-1149**	State	Zip

Information to be disclosed:

MEDICAL RECORD RELEASE

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

I need by: _____ Date

I will pick up by: _____ Date

- ☐ 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
- ☐ Immunizations
- ☐ Other (Specify) _____

Radiology Film Release:

* **Films must be picked up in Radiology Call 952-993-5427**
* Return loaned films within 30 days

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

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: