

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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By completing and signing this form you are authorizing Park Nicollet Health Services to release the information marked below. Park Nicollet Health Services includes Park Nicollet Methodist Hospital and Park Nicollet Clinic.

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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 <input type="checkbox"/> Clinic visit notes <input type="checkbox"/> Radiology reports <input type="checkbox"/> HIV or AIDS records <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Mental health records <input type="checkbox"/> Lab reports <input type="checkbox"/> Pathology reports (e.g., non-Park Nicollet records) <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Hospital _____ | | | |
| | Records concerning/Dates requested/Special instructions | | | |
| | Radiology image release (in most cases you will receive your images in digital format (CD)) <input type="checkbox"/> General X-rays Date(s) _____ <input type="checkbox"/> Nuclear medicine Date(s) _____ <input type="checkbox"/> MRI Date(s) _____ <input type="checkbox"/> Pet scan Date(s) _____ <input type="checkbox"/> CT Date(s) _____ <input type="checkbox"/> Include radiology report(s) <input type="checkbox"/> Ultrasound Date(s) _____ | | | |
| | Mammography imaging release | | | Pathology |
| | <input type="checkbox"/> 30 day loan | <input type="checkbox"/> Permanent transfer | <input type="checkbox"/> Include radiology report(s) | <input type="checkbox"/> Pathology slides |
| Purpose for release | <input type="checkbox"/> Continuation of care—Radiology <input type="checkbox"/> Continuation of care—Medical Records (6 visits or 6 months) <input type="checkbox"/> Insurance change | | <input type="checkbox"/> Insurance* <input type="checkbox"/> Out of town move (send 2 yrs) <input type="checkbox"/> Disability <input type="checkbox"/> Personal* | |
| | | | <input type="checkbox"/> Legal* <input checked="" type="checkbox"/> Other <u>PRE TRIAL DISCOVERY</u> | |
| | * 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 | | | |
| | <i>Radiology Image Release:</i> Pre-pay charges apply for images released to patient without provider/facility information | | | |
| | Facility/Provider/Insurance company/Attorney/Patient name | | | Phone # |
| | RECORDS DEPOSITION SERVICE, INC. | | | 248-357-3330 |
| | Street address | | City | State ZIP code |
| | PO BOX 5054 | | SOUTHFIELD | MI 48086-5054 |
| 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 | | | |
| | <input type="checkbox"/> On paper <input type="checkbox"/> Mail before (appointment date) ____/____/____ <input type="checkbox"/> I will pick up on (date) ____/____/____ <input type="checkbox"/> Via secure email (requires internet access) <input type="checkbox"/> Patient email address _____ | | | |
| | Billing records | | | |
| | Statement date(s) ____/____/____ - ____/____/____ <input type="checkbox"/> On paper <input type="checkbox"/> On CD (requires PDF Reader software) | | | |
| | <input type="checkbox"/> Send via US Mail <input type="checkbox"/> I will pick up on (date) ____/____/____ | | | |
| Authorization and Revocation | <p>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.</p> <p>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.</p> | | | |
| | <p>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.</p> | | | |
| Mailing instructions | Mail completed authorization to: | | For radiology images only, mail 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 | | 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 p.m. - 6 a.m.) requests (health care facilities only): | | | Fax completed form to 952-993-6496 |