Methodist Hospital

Park Nicollet Health Services
Attn: Health Information Management
PO Box 650
Minneapolis, MN 55440-0650
952-993-7600 tel 952-993-6496 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

112032AUTHH

NAME: For Office Use Only:

DOB:

MR#: HCL# :

LABEL or ADDRESSOGRAPH

Instructions

1. All sections (in red) need some kind of information from you. This request will be returned and records will be delayed if all sections are not completed. 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.

Patient:	Name	Previous Last Name (if any)	
	Address		Day Phone No.
	City	State	Zip
	Date of Birth	Social Security Number	XXX-XX-__ __ __ __
Who has the information you would like released?	Name **Methodist Hospital**		Phone No. **952-993-7600**
	Address **PO Box 650**		
	City **Minneapolis**	State **MN**	Zip **55440-0650**
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

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Anesthesiology Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ X-Ray Report
- ☐ Lab Report
- ☐ Outpatient Visit(s)
- ☐ Emergency Room Visit(s)
- ☐ HIV or AIDS Records
- ☐ Mental Health Records
- ☐ Chemical Dependency Records
- ☐ Immunizations
- ☐ Non-Park Nicollet Health Services Records
- ☐ Other (Specify)

Radiology Film Release:

* **Call Radiology at 952-993-5427 to arrange release of images.**
* Original film is loaned for 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
- ☐ Legal
- ☐ Out of Town Move (send 2 years)
- ☐ Continuation of Medical Care
- ☐ Other (Specify)

Revocation:

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing.

Authorization:

I authorize Methodist Hospital 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: