Fairview Southdale Hospital
Health Information Management
6401 France Ave. South
Edina, MN 55435-2199
Phone: 952-924-5165; Fax 952-915-8824

Office use only MR#_____

Print patient's legal name: _____ Birth date: _____/_____/_____

Previous name(s):_____ Phone: _____

1. **Please release my records from:** *(Who has your records? Please list the specific hospital and/or clinic.)*
   Name: _____
   Address:_____City:_____State:_____ Zip:_____
   Phone: _____ Fax: _____

2. **Release the records marked below for this condition or date(s) of treatment:** _____
   (if blank, we will release 1 year's worth of most recent records.)
   ☐Pertinent clinic records (office visit, lab/radiology results, medications, immunizations)
   ☐Pertinent hospital records (emergency, operative or discharge report, history and physical, lab/radiology results)
   ☐X-ray/Radiology films/CDs ☐Immunizations ☐Emergency/Urgent Care ☐EKG/echo reports
   ☐X-ray/Radiology reports ☐ Lab/Pathology reports ☐ *For MD only:* Pathology slides/tissue blocks
   ☐Other (please specify _____)

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: _____☐ Entity listed in header
   Phone:_____Fax:_____
   Address:_____City:_____ State: _____ Zip:_____

4. **Delivery/format:** Electronic**:** ☐ E-mail and/or MyChart (patient portal) ☐ US mail ☐ CD
   ☐ Fax (only for continuing care) ☐ Will pick up **Date needed by:** _____

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other _____

6. **I understand that:**
   - The release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released**: _____
   - If I want substance abuse records released, I should complete the Fairview Recovery Services Authorization to Release Protected Health Information form instead of this form.
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - My records may include records that you received from other organizations. If you have used these records and filed them in the record you maintain about me, then they may also be included in any release of information.
   - I approve the release of records for future visits, starting from the date I sign this form through:_____.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
   - This form expires one year after I sign it, or on _____, except in certain situations specified by law.

_____	_____	_____	_____
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and description of authority to sign for patient (may require proof)***