Print patient's legal name _____ *(office use only: MR#* _____ *)*
Previous names_____ Birth date _____ Social Security # _____ *(optional)*
Phone numbers (Home)_____ (Work)_____ (Other) _____

1. Please release my records from: *(Who has your records?)*
Clinic or organization (if not printed above): **FAIRVIEW RIDGES HOSPITAL**
Address: **201 E NICOLLET BLVD** City: **BURNSVILLE**
State: **MN** Zip code: **55337** Phone: _____ Fax:_____

2. Please release my records to: *(Who needs your records?)*
Person, clinic or organization (if not printed above): **RECORDS DEPOSITION SERVICE, INC.**
Address: **PO BOX 5054** City: **SOUTHFIELD**
State: **MI** Zip code: **48086-5054** Phone: **248-357-3330** Fax: **248-357-3337**
If releasing records to yourself, should the envelope be marked "Personal and Confidential"? ☐ *Yes* ☐ *No*

3. These are the records I would like to release: ☐ **All pertinent records,** or check all that apply below

☐ Discharge summary	☐ Pathology reports	☐ EKG/ECHO reports
☐ Counselor's discharge summary	☐ Lab reports	☐ Emergency or urgent care reports
☐ History and physical exam	☐ X-ray / Radiology reports	☐ Psychological tests
☐ Consultation reports	☐ Films / CDs	☐ *For MD only:* Pathology slides / tissue blocks
☐ Outpatient clinic notes	☐ Operative reports	☒ Other: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**

For condition or dates of treatment: _____ *(If blank, we will release 1 year's worth of most recent records.)*
Date records are needed by: _____. *Will records be picked up?* ☐ *Yes* ☐ *No*

4. Purpose: ☐ Continued care by another provider ☐ Insurance claim ☐ Personal use
☐ Social Security disability ☐ Attorney review ☒ Other **For Discovery Before Trial**

5. I understand the following:

- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the person, clinic or organization named above. This includes details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV.
  If I don't want these to be released, I will place a check mark here: _____. I do not want the following records released: _____.
- 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.
- This form expires one year after I sign it or sooner (specify here: _____).
  The time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records.
- Once the records are released to the person, clinic or organization named above, the clinic or hospital 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.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless treatment is part of a research project.

_____ _____ _____
Date/Time *Signature of patient or authorized person* *Authorized person's authority to sign (proof required)*

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____