FAIRVIEW
SOUTHDALE HOSPITAL

Health Information Management Services
Release of Information, LL25
6401 France Avenue South
Edina, MN 55435-2199
Phone: (952) 924-5165

Patient Name _____ (please print clearly) **Medical Record #:** _____ (for office use only)

Previous Names _____ **Social Security #** _____ (optional) **Birthdate** ___/___/___

Phone Numbers (Home) _____ **(Work)** _____ **(Other)** _____

Release Records **FROM:**	☐ Fairview Southdale Hospital *or* **Clinic/Organization Name:** _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____ ☐ **If records are being released to self, please check here if you want the envelope marked "Personal and Confidential."**
Release Records **TO:**	☐ Fairview Southdale Hospital *or* **Person/Clinic/Organization Name:** RECORDS DEPOSITION SERVICE, INC. Address: PO BOX 5054 City: SOUTHFIELD State: MI Zip Code: 48086-5054 Phone: (248) 357-3330 Fax: (248) 357-3337
Information to be Released/ Reviewed:	**The following information is to be released (check appropriate boxes):** ☐ Discharge Summary ☐ Pathology Reports ☐ Operative Report ☐ Counselor's Discharge Summary ☐ Pathology Slides ☐ EKG/ECHO Reports ☐ History and Physical Exam ☐ Radiology Reports ☐ Emergency Dept Records ☐ Consultation Reports ☐ Laboratory Reports ☐ Psychological Tests ☐ Outpatient Clinic Notes ☐ Films/CD ☐ Pertinent Information ☐ Other (specify)_____ **For the following date(s) of treatment or condition:** _____ (If dates of treatment or condition are not specified, only the last 90 days of information will be released)
Reason for Disclosure:	**I would like this information released for the following purpose:** ☐ Continued care by another provider ☐ Insurance purposes ☐ Personal use ☒ Attorney ☐ Social Security Disability ☐ Other

I have read and understood the following:

- Except for psychotherapy notes (these notes are not included in my medical record), Fairview will release all records of treatment for mental health, chemical dependency, sickle cell anemia and AIDS/HIV. If I don't want these to be released, I will place a checkmark here: _____. I do not want the following records released: _____
- If I change my mind, I may write to the address at the top of this form 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, Fairview cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- Fairview will not withhold treatment if I do not sign this form, unless it is needed for research-related treatment.

_____ _____ _____
Signature of patient or authorized person (If authorized person is signing, please also print name) | **Authorized person's authority to sign** (parent, guardian, power of attorney, etc.) | **Date**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION