6545 France Avenue S, Ste 510
Edina, MN 55435
(P) 952-285-3880
(F) 952-479-5540

MEDICAL RECORDS REQUEST FORM

Patient Information

Name____ DOB____________________

Address____________________________ City__________________ State______ Zip________

Phone_______________________ E-mail____

Release Information FROM

I authorize release of my medical records from (who has the information you want released):

Hospital/Clinic____

Address____________________________ City__________________ State______ Zip________

Phone_______________________ Fax____________________ Contact____________________

Release Information TO

I authorize release of my medical records to (where you want the information sent):

Hospital/Clinic____

Address____________________________ City__________________ State______ Zip________

Phone_______________________ Fax____________________ Contact____________________

Records Requested for Release:

_____ Prenatal Records _____ Surgical Records _____ Consultation Reports

_____ Genetic Test Results _____ Imaging Reports _____ Pathology Reports

_____ Lab Results _____ Other Records _______________________________

Reason for Release:

_____ Continuation of Care _____ Transfer of Care _____ Care for Relative

_____ Other ____

I hereby authorize for the release of records as described above. This authorization is valid for one year from the date below. I understand that I may revoke this authorization, in writing, at any time. A photocopy or fax of this authorization shall be treated as valid as the original.

____ _______________________

Patient (or Guardian) Signature Date

For Internal Clinic Use:

Date Received: ______________ Date sent: ______________ Initial: _____________