



Health Information Services
 200 University Avenue East
 St. Paul, MN 55101
 Phone: (651) 312-3122
 FAX: (651) 229-3888

Patient Name: _____ Pt. D.O.B.: _____ MR#: _____

****Please include a copy of this form with the materials requested****

I authorize the release of information and report(s) to the individual/party as stated below:

<input type="checkbox"/> Release TO Gillette Children's Specialty Healthcare Requesting Provider: _____	<input type="checkbox"/> Release FROM Gillette Children's Specialty Healthcare ATTN: _____
Name: _____	
Facility: _____	
Address: _____	
City: _____ State: _____ Zip Code: _____	
Phone: _____ FAX (if known): _____	
<input type="checkbox"/> Verbal Release Only, to: _____	

Information to be Released: Check the appropriate box(es) below regarding information to be released for the following dates:

From: _____ to _____

<input type="checkbox"/> All Pertinent – (Includes all items below or specify individual items) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Pathology Report(s) <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Consultation Report(s) <input type="checkbox"/> Outpatient Clinic Notes <input type="checkbox"/> Special Testing <input type="checkbox"/> Imaging Report(s) – (X-ray, CT, MRI, etc.)	<input type="checkbox"/> Other – (Please specify individual options) <input type="checkbox"/> Imaging Exam(s) – (X-ray, CT, MRI, etc.) <input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Growth Charts <input type="checkbox"/> School/Academics/IEP <input type="checkbox"/> Media (photos, videos, and other diagnostic imagery) <input type="checkbox"/> Rehabilitation Report(s), specify: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Therapeutic Rec <input type="checkbox"/> Other: _____
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* The following information will not be released unless initialed by patient or legal guardian:

_____ Psychiatric / SW Discharge _____ Psychology Evaluation _____ AIDS /HIV _____ Chemical Dependency

Please indicate any release restrictions: _____

Information to be Disclosed will be used for: Check the appropriate box(es) and include other info where indicated

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Litigation	<input type="checkbox"/> Personal	<input type="checkbox"/> Education
<input type="checkbox"/> Other, specify: _____				

- I understand that I may revoke this authorization at any time by WRITTEN REQUEST.
- I understand that the revocation will not apply to information already released in response to this authorization.
- A photocopy or facsimile of this authorization will be treated in the same manner as the original.
- I understand that once information is released pursuant to this authorization, Gillette Children's Specialty Healthcare cannot prevent the re-disclosure of the information to a third party.
- I understand that Gillette Children's Specialty Healthcare may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- **I understand there may be a charge associated with the Release of Information Services rendered; MN Statute 144.292. There is no charge for release of information to other health care facilities.**

This authorization will expire ONE YEAR following the date of signature except in the case of continuing care. Information released only includes information up to the date of signature.

(All lines must be completed)

 Patient/Parent/Legal Responsible party Initials Relationship** Date
** Proof of Guardianship may be required

----- (Office Use Only) -----

Date Received: _____ Date Processed: _____ Request Completed by: _____

8083-003
 12/04, 05/06, 04/08, 05/09, 07/09

Authorization to Release Information