Gillette Children's
Specialty Healthcare

Patient Access - 010601
200 University Ave East
St. Paul, MN 55101
Phone: (651) 265-7329
FAX: (651) 325-2137

Records Needed by: _____

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:

☐ **Release TO Gillette Children's Specialty Healthcare**	☐ **Release FROM Gillette Children's Specialty Healthcare**
Requested By: _____	ATTENTION: _____

Contact: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ FAX (if known): _____

☐ **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** _____

☐ **Records Pertaining to:**

- ☐ Discharge Summary
- ☐ Operative Report(s)
- ☐ History & Physical Exam
- ☐ Outpatient Clinic Notes
- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Consultation Report(s)
- ☐ Special Testing
- ☐ Imaging Report(s) – *(X-ray, CT, MRI, etc.)*
- ☐ Birth record/NICU notes

☐ **Other –** (Please specify individual options)

- ☐ Imaging Exam(s) – *(X-ray, CT, MRI, etc.)*
- ☐ Discharge Instructions
- ☐ Growth Charts
- ☐ School/Academics/IEP
- ☐ Media *(photos, videos, and other diagnostic imagery)*
- ☐ Rehabilitation Report(s), specify:
  - ☐ PT ☐ OT ☐ Speech Therapy ☐ Therapeutic Rec
- ☐ Initial and most recent eval and last progress note
- ☐ Other:

** The following information will not be released unless initialed by patient or legal guardian:*

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

☐ By checking this box, I do NOT agree to allow Gillette to release or access my electronic health information through a health information exchange, or a record locator service, for any purpose, even in a medical emergency.

Please indicate any release restrictions: _____

Information to be Disclosed will be used for Continuing Care

I understand that:

- I may revoke this authorization at any time by **WRITTEN REQUEST**.
- Revoking my authorization 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 if it were the original form.
- Once information is released because of this authorization, Gillette cannot prevent re-disclosure of the information by a third party.
- Gillette may not make treatment, payment, enrollment or eligibility for benefits a condition of my signing this form.

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)

Please sign here

_____ _____ _____

Patient/Parent of minor/Legal Responsible party *Relationship Date

***Proof of Guardianship/Durable POA/court order may be required**

(Office Use Only)

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

Patient Access – Authorization to Release Information