SHAKOPEE MDEWAKANTON

PUBLIC SAFETY

Medical Records Request

Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____
Date of Birth: _____

I request the release of medical records for service provided by Mdewakanton Public Safety Services on the following date(s):_____.

Please send the records listed to:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

I understand that I may revoke this authorization at any time with written notification, but that this revocation will not have any effect on information which has already been released prior to my written request.
If this form is used to authorize the release of information from Mdewakanton Public Safety, I understand that Mdewakanton Public Safety cannot prevent the re-disclosure of records released to a third party as a result of this request. Mdewakanton Public Safety is thus released from any liability resulting from such re-disclosure.

I have read and understand the above release of information request.

Signature of Patient: _____ Date: _____

Printed Name:_____

Return to:
Mdewakanton Public Safety
2330 Sioux Trl NW
Prior Lake, MN 55372
Fax: 952-233-9265