Minnesota Historical Society

State Archives Hospital Record Research Request Form

(usually ships within 30 days)

Hospital name: ______________________________

Name on record: ______________________________

Date of birth: ____________ **Date of death:** ____________

Admission date (if known) ____________ **Discharge date (if known)** ____________

My purpose in using these records is:

______ Family history, genealogy. My relationship to that person is:

______ To see private information about myself.

______ Attorney or other authorized representative of another party. Evidence of authorization may be required.

My name: ______________________________

My address: ______________________________

City/State: ______________________ **Zip**: ____________

Daytime phone: (   ) ____________ **Email address**: ____________

FAX: (   ) ____________ **MHS member number** (10% discount): ____________

FEES:

______ **$25.00** for MN residents

______ **$30.00** for non-MN residents

Payment:

_______ **Check** (made payable to: Minnesota Historical Society)

_______ **VISA** _______ **MasterCard** _______ **Am. Express** _______ **Discover**

Card number ______________________ **Exp. Date**: ____________

Signature of cardholder: ______________________________

---MHS Use Only---

Proof of death attached ____________ Proof of identity ____________

MHS staff approval ______________________________