Minnesota Epilepsy Group, P.A.®

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Authorization For The Use and Disclosure of Protected Health Information

PATIENT NAME (LAST - FIRST - MIDDLE)		PREVIOUS LAST NAME (IF APPLICABLE)	
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER ( )	BIRTHDATE / /	SOCIAL SECURITY NO.	

INFORMATION RELEASED FROM	INFORMATION RELEASED TO/EXCHANGED WITH
NAME OF CLINIC	NAME (HOSPITAL, CLINIC, ATTORNEY, INSURANCE COMPANY, INDIVIDUAL)
FACILITY ADDRESS	STREET ADDRESS
CITY STATE ZIP	CITY STATE ZIP
	DATE INFORMATION NEEDED

Indicate information to be disclosed:

- ☐ Medical history summary
- ☐ Office visit summaries
- ☐ Diagnostic neuroimaging reports
- ☐ Neuroimaging films
- ☐ Surgery report
- ☐ Mental health records
- ☐ EEG reports
- ☐ Laboratory results
- ☐ Neuropsychological testing
- ☐ Educational records (IEP, assessment summary report, grades, attendance record)
- ☐ Other _____

The disclosure is for the following purpose(s):

- ☐ Insurance Application
- ☐ Litigation
- ☐ Other
- ☐ Patient/Guardian Request
- ☐ Disability Determination

Information Limitations - List restrictions on information to be released, if any:

I give permission to use and disclose protected health information as indicated above. I understand that I may cancel this authorization at any time by notifying Minnesota Epilepsy Group, P.A. in writing and my cancellation will take effect when Minnesota Epilepsy Group, P.A. receives my written notice. I understand that my cancellation will not have any effect on information released before Minnesota Epilepsy Group, P.A. received my written notice of cancellation. I understand that when Minnesota Epilepsy Group, P.A. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand that this authorization will take effect on the date signed and will be in effect until canceled by me in writing or when it expires in one year in accordance with Minnesota law. I authorize the use of a telefax and/or photocopy of this form for the use and disclosure of protected health information as described above. I understand there may be a charge associated with the retrieval, copying and sending of records. I understand and agree to the terms of this authorization.

SIGNATURE OF PATIENT OR PERSON LEGALLY AUTHORIZED TO ACT ON HIS/HER BEHALF:	DATE SIGNED
IF NOT SIGNED BY PATIENT, RELATIONSHIP TO PATIENT (E.G., LEGAL GUARDIAN)	REASON PATIENT UNABLE TO SIGN