Minneapolis Clinic of Neurology

4225 Golden Valley Rd., Golden Valley, MN 55422

(763)-302-4125 AUTHORIZATION FOR DISCLOSURE FAX (763)-287-2318

Patient Name _____ Former Name _____

Address _____Date of Birth_____

City _____ State _____ Zip Code _____ Date Needed By _____

This Will Authorize: Minneapolis Clinic of Neurology

Disclosure/Release to: _____

Address _____ City _____ State _____ Zip _____

We can fax records to a clinic only. Dr._____Fax _____

Clinic Name _____ Phone _____

Information disclosed for the following purposes:

_____Continuation of Care _____Litigation

_____Insurance Claim _____Other:_____

Information Authorized for Disclosure: (check medical record set for entire file or check individual documents)

___Medical Record Set * ____Lab Reports _____ MRI CD Disk

(* Includes all reports listed, except for MRI CD) ____EMG Report _____MRI Report

___Consultation Report ____EEG Report

___Mental Health Reports ____Other _____

___PT / BTF Records & Reports

Dates of service if known: _____

- The designated record set may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, child abuse, or alcohol/drug abuse treatment.
- This Authorization for Disclosure will expire in one year
- This authorization for disclosure may be revoked at anytime if done in writing and presented to Medical Records
- Revocation will not apply to information already disclosed with this authorization for disclosure and/or information disclosed for purposes of treatment, payment and health care operations.
- Refusal to sign this Authorization for Disclosure will not affect treatment
- Authorized disclosure of information may be subject to unauthorized re-disclosure.

_____ _____

Signature of Patient / Parent or Legal Guardian Date of signature

Relationship to patient (if non-patient signature) Specify _____