Minneapolis Clinic of Neurology
4225 Golden Valley Rd., Golden Valley, MN 55422
Phone: (763) 302-4125 | Fax: (763) 302-4087

I authorize Minneapolis Clinic of Neurology to release and disclose my medical records as specified here.

Patient Name _____

Former Name (if applicable)_____ Date of Birth_____

Address _____ Phone_____

City _____ State _____ Zip Code _____ Date Needed By _____

Disclosure/Release to: _____
(*Include Clinic and Provider Name, Self, or Other Organization Name*)

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Information disclosed for the following purposes:

_____Continuation of Care _____Litigation
_____Insurance Claim _____Other:Disability

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 / OT 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
"MUST BE INK-SIGNED"
Relationship to patient (if non-patient signature) Specify _____