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):

- ☐ For Research Purposes
- ☐ Transfer Records to New Health Care Provider
- ☐ Patient/Guardian Request
- ☐ Other___________________________

I give permission to use and disclose protected health information as indicated above. I understand that Minnesota Epilepsy Group, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, Minnesota Epilepsy Group, P.A. will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Minnesota Epilepsy Group, P.A. will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to Laurie Colbeck. If I revoke this authorization, Minnesota Epilepsy Group, P.A. will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. 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.

This authorization shall expire ______________________________(not to exceed one year from the date signed).

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