MN EpilepsyGroup
Focused expertise. Comprehensive care.

Authorization to Discuss Medical Information with Others March 30,2022

Many of our patients allow other family members or others such as their spouse, significant other, parents or children to call and request the results of tests, procedures, and financial information. Under requirements for HIPAA we are not allowed to give this information to anyone without the patient/guardian's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to others you must fill out and sign this form.

This consent will not expire unless it is canceled in writing to: **Medical Records Manager, Minnesota Epilepsy Group, P.A.** If you cancel your consent, it will not change the releases/discussions that have already been made.

I authorize Minnesota Epilepsy Group, P.A. to discuss information requested with the following individuals.

1. _____ Relation to Patient:_____

Home:_____Cell:_____Work:_____

2. _____ Relation to Patient:_____

Home:_____Cell:_____Work:_____

Authorization Regarding Phone Messages

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments.
_____ I authorize you to leave detailed messages on my home or cell numbers regarding medical treatment, care, test results or financial information.
_____ I authorize you to leave a message with anyone who answers the phone.
_____ Messages may only be left with _____.

Comments:_____
_____
_____
_____

PATIENT'S NAME (please print): _____ DATE OF BIRTH: _____

SIGNATURE OF PATIENT (if applicable): _____ DATE: _____

NAME OF LEGAL GUARDIAN (if applicable) (please print): _____

SIGNATURE OF LEGAL GUARDIAN (if applicable): _____DATE: _____