

**Noran Neurological Clinic/Minnesota Diagnostic Center
Authorization to Use/Disclose Health Care Information**

Patient Name: _____ aka: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____

Date of birth: _____ Social Security Number: _____

To whom should the information be sent:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax #: (include area code) if documents are to be faxed: _____

If records are to be emailed, please indicate an email address: _____

Who has the information you would like released:

Noran Neurological Clinic/Minnesota Diagnostic Center
2828 Chicago Ave S Ste 310
Minneapolis, MN 55407
Phone: 612.879.1560 Fax: 612.879.0722 Email: records@noranclinic.com

Information to be disclosed: (please check below and indicate date range)

<input type="checkbox"/> consultation/lookup reports	<input type="checkbox"/> school records
<input type="checkbox"/> radiology reports	<input type="checkbox"/> psychological testing/reports
<input type="checkbox"/> lab reports	<input type="checkbox"/> forms/questionnaires
<input type="checkbox"/> EMG report	<input type="checkbox"/> radiology films/CD
<input type="checkbox"/> EEG report	<input type="checkbox"/> other _____

Please note - if you have participated in a research study through Noran Clinic/Minnesota Diagnostic Center, those records regarding your participation in the study may be included in your Noran Clinic/Minnesota Diagnostic Center chart. To withhold these records from this release, please check here ___
Please note - records related to mental health, HIV, alcohol and/or drug treatment will be released unless a check mark is placed here ___

Revocation/Expiration:

I understand that this authorization will be in effect for 12 months unless revoked by me in writing. I may revoke this authorization by filling out a form available from Noran Neurological Clinic/Minnesota Diagnostic Center or by writing a letter to Noran Neurological Clinic/Minnesota Diagnostic Center stating that I want to revoke this authorization. This revocation will take effect when the provider receives my notice in writing. I understand that my revocation does not affect records that have been previously disclosed.

Reason for Disclosure: (please check)

at my request continuing care litigation insurance claims
 other _____

I understand that once Noran Neurological Clinic/Minnesota Diagnostic Center has disclosed health care information I have authorized to be disclosed, Noran Neurological Clinic/Minnesota Diagnostic Center has no control over the information. The person or organization that I authorized to receive the information might re-disclose it. It may no longer be protected by privacy laws. I understand that Noran Neurological Clinic/Minnesota Diagnostic Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Signature

Date

if not patient, relationship to patient

if patient is unable to sign, reason patient is not able to sign

witness