**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: _____ Last Four of SSN: _____

**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

**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: _____

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

__consultation/followup reports
__radiology reports
__lab reports
__EMG report
__EEG report
__sleep study
__school records
__psychological testing/reports
__forms/questionnaires
__radiology films/CD (mailed or pick up only)
__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 ___ .
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*