Noran Neurological Clinic, P.A./Minnesota Diagnostic Center
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT: DOB: Account #

Who has the information you would like released:
Noran Neurology ATTN: Medical Records
France Place
3601 Minnesota Drive, Suite 200
Bloomington MN 55435 Phone: 612.879.1560 Fax: 612.879.0722 Email: records@noranclinic.com

To whom should the information be sent:
Name:
Address:
City: State: Zip:
If being faxed, please indicate fax # with area code: _____
If records are to be emailed, please indicate an email address: _____

Information to be disclosed: (please check)
Please indicate date range _____ or if no date range indicated, please send any or all records.

__consultation/followup reports
__radiology reports
__lab reports (Dates:_____)
__EMG report
__EEG report
__school records
__psychological testing/reports
__forms/questionnaires
__radiology imaging/image share page
__other _____
__ medication history

**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 that 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. A photocopy shall be as valid as the original.

_____

Signature **Date**

_____

If not patient, state relationship to patient. If patient is unable to sign, state reason patient is unable to sign.