

Please complete boxes
**1-10 and sign and date the
bottom ONLY!**

Of the “**PATIENT REQUEST FOR
RELEASE OF MEDICAL RECORDS**”
for each Physician, Hospital or Clinic
where you have been seen.

**We will fill out the rest of
the form for you.**

If you need more forms or have
questions about filling out any of the
forms, call us at (651) 241-5261.

Thank You

Minnesota Epilepsy Group, P.A.[®]

225 Smith Avenue North, Suite 201, St. Paul, MN 55102-2697

Phone: (651) 241-5290 Fax: (651) 241-5248

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME (LAST - FIRST - MIDDLE) 1		PREVIOUS LAST NAME (IF APPLICABLE) 2															
STREET ADDRESS 3		CITY 4	STATE 5														
		ZIP 6															
TELEPHONE NUMBER 7()	BIRTHDATE 8 / /	SOCIAL SECURITY NO. 9															
INSTITUTION FROM WHICH RECORDS ARE BEING REQUESTED 10																	
<p>Please release to Minnesota Epilepsy Group, P.A. the following medical records for the above named patient:</p> <table><tr><td><input type="checkbox"/> Medical history summary</td><td><input type="checkbox"/> EEG reports</td></tr><tr><td><input type="checkbox"/> Office visit summaries</td><td><input type="checkbox"/> Laboratory results</td></tr><tr><td><input type="checkbox"/> Diagnostic neuroimaging reports</td><td><input type="checkbox"/> Neuropsychological testing</td></tr><tr><td><input type="checkbox"/> Neuroimaging films</td><td><input type="checkbox"/> Educational records (IEP, assessment summary report, grades, attendance record)</td></tr><tr><td><input type="checkbox"/> Surgery report</td><td><input type="checkbox"/> Other _____</td></tr><tr><td><input type="checkbox"/> Mental health records</td><td>_____</td></tr><tr><td></td><td>_____</td></tr></table>				<input type="checkbox"/> Medical history summary	<input type="checkbox"/> EEG reports	<input type="checkbox"/> Office visit summaries	<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Diagnostic neuroimaging reports	<input type="checkbox"/> Neuropsychological testing	<input type="checkbox"/> Neuroimaging films	<input type="checkbox"/> Educational records (IEP, assessment summary report, grades, attendance record)	<input type="checkbox"/> Surgery report	<input type="checkbox"/> Other _____	<input type="checkbox"/> Mental health records	_____		_____
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<input type="checkbox"/> Surgery report	<input type="checkbox"/> Other _____																
<input type="checkbox"/> Mental health records	_____																

11 FOR OFFICE USE ONLY – RECORDS COORDINATOR																	
Please----- <input type="checkbox"/> Fax ----- <input type="checkbox"/> Mail		The disclosure is for the following purpose(s):															
Records Needed By _____ / _____ / _____		<input type="checkbox"/> Insurance Application	<input type="checkbox"/> Patient / Guardian Request														
		<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Litigation														
		<input type="checkbox"/> Other _____															
12																	
<p>I give permission to use and disclose protected health information as indicated above. I understand that I may cancel this authorization at any time by notifying Minnesota Epilepsy Group, P.A. in writing and my cancellation will take effect when Minnesota Epilepsy Group, P.A. receives my written notice. I understand that my cancellation will not have any effect on information released before Minnesota Epilepsy Group; P.A. received my written notice of cancellation. 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. I understand that this authorization will take effect on the date signed and will be in effect until canceled by me in writing or when it expires in one year in accordance with Minnesota law. I authorize the use of a telefax and/or photocopy of this form for the use and disclosure of protected health information as described above. I understand there may be a charge associated with the retrieval, copying and sending of records. I understand and agree to the terms of this authorization.</p>																	
PATIENT SIGNATURE 13		DATE OF REQUEST 14															
GUARDIAN SIGNATURE (IF APPLICABLE) 15																	
- FOR OFFICE USE ONLY – RECORDS COORDINATOR																	