

Complete boxes

1, 2, 10, 13, and 14 *ONLY*  
of the “**PATIENT REQUEST FOR  
RELEASE OF MEDICAL RECORDS**” for  
each Physician, Hospital or Clinic you have  
been seen at.

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) 241-8053.**

Thank You

**Minnesota Epilepsy Group, P.A.<sup>®</sup>**  
 225 Smith Avenue North, Suite 201, St. Paul, MN 55102-2534  
 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		
TELEPHONE NUMBER (      ) 7		BIRTHDATE /    / 8	SOCIAL SECURITY NO. 9		
<b>INSTITUTION FROM WHICH RECORDS ARE BEING REQUESTED</b> 10					
<p><b>Please release to Minnesota Epilepsy Group, P.A. the following medical records for the above named patient:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Medical history summary  <input type="checkbox"/> Office visit summaries  <input type="checkbox"/> Diagnostic neuroimaging reports  <input type="checkbox"/> Neuroimaging films  <input type="checkbox"/> Surgery report  <input type="checkbox"/> Mental health records         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> EEG reports  <input type="checkbox"/> Laboratory results  <input type="checkbox"/> Neuropsychological testing  <input type="checkbox"/> Educational records (IEP, assessment summary report, grades, attendance record)  <input type="checkbox"/> Other _____            _____            _____         </td> </tr> </table>				<input type="checkbox"/> Medical history summary <input type="checkbox"/> Office visit summaries <input type="checkbox"/> Diagnostic neuroimaging reports <input type="checkbox"/> Neuroimaging films <input type="checkbox"/> Surgery report <input type="checkbox"/> Mental health records	<input type="checkbox"/> EEG reports <input type="checkbox"/> Laboratory results <input type="checkbox"/> Neuropsychological testing <input type="checkbox"/> Educational records (IEP, assessment summary report, grades, attendance record) <input type="checkbox"/> Other _____ _____ _____
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Please Fax <input type="checkbox"/> Mail <input type="checkbox"/> Records needed by _____/_____/_____					
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.					
PATIENT SIGNATURE 13		DATE OF REQUEST 14			
GUARDIAN SIGNATURE (IF APPLICABLE) 15					
- FOR OFFICE USE ONLY - RECORDS COORDINATOR					