Patient Name Last First MI

Date of Birth

I hereby authorize:
(Name and address of releasing facility)

Northland Neurology & Myology, PA
1000 East First Street
Duluth, MN 55805
Phone: 218.722.1122
Fax: 218.722.0600

To Release Information to:
(Individual name, facility/organization and address)

Purpose of Disclosure:

( ) Continuing Care
( ) School .
( ) Legal
( ) Personal Use
( ) Payment of Claim
( ) Worker's Compensation
( ) Other (please specify) _____

I specifically authorize the release of information relating to:
( ) Substance abuse (including alcohol/drug use)
( ) Behavioral Health
( ) HIV related information (AIDS related testing)

Signature of Patient or Personal Representative

Date

Information To Be Released:

	Between dates of:		Between dates of:
( ) Discharge Summary		( ) X-Ray Reports	
( ) H & P Exam/ Initial Evaluation		( ) X-Ray Films/MRI	
( ) Consult		( ) Diagnostic Test Reports	
( ) Counselor/Therapist Summary		( ) Procedure Reports	
( ) Progress Notes/Provider Notes		( ) Lab Reports/Pathology	
( ) Orders		( ) Correspondence	

( ) Other (specify contents and dates): _____

Expiration Date of Authorization
This authorization is effective for one year unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Northland Neurology.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

Signature

Name of patient (print or type)

Signature of Patient

Date

Signature of Patient Representative and Relationship to Patient