_____ _____

Patient Name: Last First MI Date of Birth

I hereby authorize:

Northland Neurology & Myology, PA
1000 E 1st Street, Ste. 105
Duluth, MN 55805
p. 218-722-1122
f. 218-722-0600

To release information to:

_____

_____

_____

Purpose of disclosure:

( ) Continuing care
( ) School
( ) Legal Use
( ) 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

Records to be released between the dates of: _____ - _____
MM/DD/YY MM/DD/YY

( ) Discharge Summary
( ) H&P Exam/Initial Evaluation
( ) Consult
( ) Counselor/Therapist Summary
( ) Progress Notes/Provider Notes
( ) Orders
( ) X-Ray/MRI reports
( ) X-Ray/MRI Films
( ) Diagnostic Test Reports
( ) Procedure Reports
( ) Lab Reports/Pathology
( ) Correspondence
( ) Other (specify contents and dates): _____
( ) All medical records listed above

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 o payment for my health care.

Signature:

_____
Name of patient (print or type)

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative (and relationship to Patient)