AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

MN EpilepsyGroup
Focused expertise. Comprehensive care.

Patient Information:	Name:		DOB:
	Address:		Phone:
	City:	State:	Zip:
Check all that apply:	☐ I authorize MEG to release my documents to the person or organization below ☐ I authorize MEG to communicate verbally with the person or organization below ☐ I authorize the person or organization below to release copies of my documents to MEG at **225 Smith Avenue North, Suite 201 St. Paul MN 55102 (Fax: 651-241-5248)**		
Health Information to/From:	Person:		Organization:
	Address:		Fax:
	City:	State:	Zip:

Information to be released/received:

Date of Service to be released:_____ (if left blank, we will release one year's worth of records)

Routine Record Set:

☐ Clinic (office visit, lab, radiology, EEG)

☐ Hospital (history and physical, discharge summary, lab, consults, radiology, EEG)

☐ CD of MRI/CT of Head ☐ Any and all records (includes all types as below)

Only records checked below:

☐ History and Physical ☐ EEG reports

☐ Discharge Summary ☐ Laboratory results

☐ Office visit Notes ☐ Mental Health Records

☐ Radiology Reports ☐ Neuropsychological testing

☐ CD of MRI or CT of Head ☐ Educational records (IEP, assessment summary report, grades)

☐ Other _____

All information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing the following:

_____DO NOT Release Alcohol/Drug Use or Abuse Records _____DO NOT Release HIV/AIDS Records

_____DO NOT Release Mental Health records

Release Instructions:

Date information is needed:_____ (Please allow 7-10 for processing)

Release method/format requested: (check one)

☐ Mailed ☐ Fax

☐ Pick up by patient/authorized designee (Photo ID required) Name:_____

Purpose of Release:

☐ For Research Purposes ☐ Patient/Guardian Request

☐ Transfer record to new healthcare provider ☐ Other _____

I give permission to use and disclose protected health information as indicated above. I understand that Minnesota Epilepsy Group, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

• If the medical information to be disclosed will result from treatment for research purposes, Minnesota Epilepsy Group, P.A. will not provide the treatment if I am unwilling to sign this authorization form.
• If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Minnesota Epilepsy Group, P.A. will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to Laurie Colbeck. If I revoke this authorization, Minnesota Epilepsy Group, P.A. will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. 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.

This authorization shall expire _____ (not to exceed one year from the date signed).

X_____ X_____

Signature (If signing for minor patient, I hereby state that my parent rights have not been revoked by a court of law) **(Date)**

_____

Relationship to patient (if not patient)

NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Proof of guardianship/Durable POA/court order may be required.

Instructions for Completing Authorization to Release Health Information

Minnesota Epilepsy Group (MEG) recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact MEG with any questions concerning this form. Be sure to complete all sections of the form. **An incomplete form will delay processing!**

Patient Information: Complete the entire section which identifies clearly and legibly all the demographic information specific to the patient (individual who information is being requested for)

Check all that apply: Tell us if you want MEG to release documents, receive documents, and/or only exchange information verbally. You may check all 3 options.

Health Information to/from: Identify the full name, address, phone, fax and contact information of the individual or organization releasing or receiving information.

Information to Be Released/Received: This section gives us the instructions for what information you want shared. If you select “Routine Record Set” for hospital or clinic, we will disclose the documents that are specific to that patient care visit. This is typically what doctors’ offices, hospitals or other health care providers need to provide information related to your care. If you select “any and all” records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor. If you don’t indicate a specific date or date range, we will release one years’ worth of records.

Release Instructions: This tells us how you would like your information delivered: by mail, fax or pick up. Note: please allow 7-10 business days for processing of the Release of Information. In some cases, it can take up to 30 days (Federal statue 45 CFR164.524(b)(2)(i)).

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient or parent of a minor child, you will be required to provide written proof of your authority such as guardianship papers, durable power of attorney or court orders. This is in accordance with MN statue 144.293 (Subd.2(1)). Unless otherwise noted this consent will automatically expire in one year from the date signed. The authorization can be revoked at your written direction to our organization.

Contact Information for Patient Record Copies

Minnesota Epilepsy Group
225 Smith Avenue North, Suite 201
St. Paul, MN 55102
Phone 651-241-5287
Fax 651-241-5248