Metropolitan Neurosurgery, P.A.
Authorization for Use and Disclosure of Protected Health Information

I authorize Metropolitan Neurosurgery, P.A. to use or disclose the protected health information of the individual named below as indicated. Incomplete or invalid requests will be returned to the proper individual.

Patient Name ______________________	**Date of Birth** ______________________
Address ______________________	**SSN** ______________________
City ______________________	**Home Phone #** ______________________
State __________ **Zipcode** __________	**Work Phone #** ______________________

INFORMATION RELEASED FROM:

____
Name
____
Address
____
City
____
State Zipcode

INFORMATION RELEASED TO:
(There may be a charge incurred for this service)

____
Name
____
Address
____
City
____
State Zipcode

This authorization is for the following information (check those that apply) and indicate the needed dates of service:

____ Office Notes ____ Laboratory Reports
____ Diagnostic Test ____ Radiology Reports
____ Other______________________

Dates of Service to be Used/Disclosed:
___/___/_____ to ___/___/_____
Other______________________

The purpose for this request is (circle one) Medical Care – Legal – Insurance – Personal

I understand that sensitive information including information regarding HIV/AIDS, alcohol and drug abuse and/or mental health treatment may be released as part of this disclosure unless I initial here and indicate what sensitive information I do not want disclosed. Initials:_____ Information not to be disclosed is ____.

I understand that signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practices notices I have received. I understand that I can revoke this authorization in writing by sending notice to the clinic releasing the above information. I understand that once information is disclosed it may no longer be protected by federal and state privacy rules and therefore may be re-disclosed by the recipient of the information without protections. I understand there may be a charge for copies of my records per Minnesota Statute 144.335.

Unless otherwise indicated here this authorization shall expire in one year. Other expiration date_______
I understand the terms of this form and authorize the disclosure/use as indicated above.

______________________________ ______________________________
Patient (or Patient Representative) Signature Date

If signed by Patient Representative, state authority to do so and attach documentation to verify this fact:

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