

## PATIENT INFORMATION RELEASE

Patient Name (Last — First — Middle)		Previous Last Name (if any)	
Street Address		City	State
Zip Code			
Birthdate	Telephone Number	Social Security Number	

**PROVIDER**

**REQUESTOR**

Who HAS the information you would like released?	Who should the information be sent TO?
<input type="checkbox"/> <b>MINCEP<sup>®</sup> Epilepsy Care</b> <input type="checkbox"/> <b>Minnesota Comprehensive Epilepsy Program<sup>®</sup></b>	Name: _____ Address: _____ _____
<input type="checkbox"/> Name: _____ Address: _____ _____	<input checked="" type="checkbox"/> <b>MINCEP<sup>®</sup> Epilepsy Care</b> <input checked="" type="checkbox"/> <b>Minnesota Comprehensive Epilepsy Program<sup>®</sup></b> <b>5775 Wayzata Boulevard</b> <b>Suite 200</b> <b>Minneapolis, MN 55416</b>

**RELEASED INFORMATION SHOULD INCLUDE:**

<input type="checkbox"/> Medical records relating to Seizure Diagnoses and Treatment <input type="checkbox"/> EEG/Video EEG Reports <input type="checkbox"/> Imaging: CT, MRI, PET, SPECT, MEG, etc. <input type="checkbox"/> Antiepileptic Drug Levels	<b>Neuropsychological Testing</b> <input type="checkbox"/> Complete Battery <input type="checkbox"/> MMPI <input type="checkbox"/> Abbreviated Batteries  <b>Mental Health Records</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Other _____ _____ _____
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**MEDICAL CONDITION / INJURY**

Describe Medical Condition/Injury	<b>TIME PERIOD</b>	
	FROM (M/D/Y)	TO (M/D/Y)

**INFORMATION LIMITATIONS (IF ANY)**

List any restrictions on information to be released

I give permission to the PROVIDER to release Medical Record Information concerning the MEDICAL CONDITION/INJURY described above to the Requestor and its associated hospitals, medical treatment center, clinics, health or nursing centers, and the medical personnel thereof, and to other appropriate persons in accordance with acceptable medical practice. The information released may include, but not be limited to, that which involves the treatment for alcohol or drug abuse; will be restricted to any INFORMATION LIMITATIONS outlined above and may be used only for the purpose of treatment and related use/education/research.

I understand that I may be responsible for the reasonable costs associated with the release-of-information services rendered.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect with respect to information released before my PROVIDER receives my written notice.

I understand that this release will take effect on the date signed and will be in effect until canceled by me hereafter.

<b>Date and Signature</b>	Date Signed	Signature of Person Releasing Information <b>X</b>	
<b>If NOT Signed by Patient</b>	Relationship to Patient	Reason Patient Unable to Sign	
Information Sent By:	Date Sent	<b>WHITE — Medical Record Copy</b> <b>YELLOW — Attach to information</b> <b>PINK — Patient's Copy</b>	