Neurosurgical Associates, Ltd.

Brain and Spine Specialists
913 E 26th Street • 305 Piper Building • Minneapolis, MN 55404 P: 612-871-7278 F:612-863-8531

Authorization For Release Of Medical Information

Patient Information

Patient Name | Date of Birth | Social Security No.

Address (Street, City, State, Zip) | Telephone No.

Who has the information you would like released:

____ Neurosurgical Associates, Ltd.

-OR-

Facility Name

Address (Street, City, State, Zip)

To whom should the information be disclosed to:

____Neurosurgical Associates, Ltd.

- OR-

Facility Name

Address (Street, City, State, Zip)

If applicable, "To the attention of"

(_____)_______-_____________________________
If applicable, fax number

Information To Be Disclosed:

___ Complete Chart **-OR-** ___ Treatment Date(s):_______________ to _______________

-OR-

___ Office Notes
___ Radiology Reports
___ Operative / Discharge Reports
___ Lab
___ Forms/Questionnaires
___ Telephone Notes
___ Other: ________________________

*We do not release outside records. Please contact original creator for those records.

Reason for disclosure: (check one)

___ Continuing care
___ Personal use
___ Insurance claims
___ Litigation
___ Other ____

Expiration:

This authorization expires one year from the date signed below and covers only treatment for the dates specified above. I may revoke this authorization by writing a letter to Neurosurgical Associates stating that I want to revoke this authorization. This revocation will take effect when the provider receives my notice in writing. I understand that my revocation does not affect records that have been previously disclosed.

I have read this authorization form and agree to its terms.

Signature of Patient or Representative | Relationship to Patient

Date