Child Neurology SOLUTIONS

Authorization to Release Protected Health & Other Information

CNS Patient #	Name (*First, Middle, Last*)	Birth Date (*month, day, year*)

Release Information From:

Name	Role	Clinic/Agency	Address	phone #	fax #
	Primary provider				

Release Information To:
Elizabeth E. Gilles, MD
Fort Road Medical Building
360 Sherman Street, Suite 399

Phone #: (651) 356-6080
Fax #: _____

Purpose of Release:
☐ Treatment
☐ Continuity of care
☐ Insurance
☐ _____

Service Dates
From _____ to _____

Information needed by: _____

Information to be Released:
☐ Outpatient (office) notes
☐ School records
☐ Hospital records (admit, discharge, progress notes, consultations, op notes)
☐ Emergency Department notes
☐ Laboratory/Pathology/Imaging reports
☐ Imaging CD

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship if not the parent: _____.
- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship: Legal Guardian Health Care Power of Attorney

Signature *(Required)*	**Date Signed** *(Required)* *(Month DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*	
Mailing Address of Patient - Street	

City	State	ZIP Code	Phone

I understand the information to be released may include records related to behavior and/or mental health care, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from today the date of signing unless I indicate an earlier date here: _____.