St. Cloud
Neurobehavioral
Associates, P.A.

3812 8th St. N., Ste. 200
St. Cloud, MN 56303
Phone: 320-258-3833
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
Last First Middle

FORMER NAME(S): _____
Last First Middle

DATE OF BIRTH: ____/_____/_____ **TELEPHONE:** _____

ADDRESS: _____
Street Apt. / Lot#

_____
City State Zip Code

EXCHANGE WITH: _____ **DISCLOSED TO:** _____ **OBTAIN FROM:**_____

NAME: _____

ADDRESS: _____
Street

_____
City State Zip Code

TELEPHONE: _____ **FAX:**_____

Dates of medical records to be released:_____**THROUGH**_____

_____Discharge Summary
_____Progress Notes/Clinical Notes
_____Psychological Information/Evaluation
_____Psychiatric Information/Intake
_____Any or All MRI/EEG/CT Scan(Brain/Head only)
_____ Diagnostic Assessment
_____ Neuropsychological Evaluation
_____ Neurology Information/Intake
_____ Emergency Room Report
_____Report Cards, Intervention Data
_____IEP/Evaluation Report/504 Plan
_____Attendance Records/Behavioral Reports
_____Other_____

Delivery of medical records: _____Fax _____Mail _____Pick up (Photo ID required)

THIS INFORMATION WILL BE USED FOR_____

This Authorization will remain in effect a maximum of one year from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

Further, I realize that St. Cloud Neurobehavioral Associates cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections, therefore St. Cloud Neurobehavioral Associates is released from any and all liability resulting from redisclosure. I have read and understand my rights.

Signature of Patient/Guardian:_____ **Date:** _____
Relationship to Patient: SELF PARENT GUARDIAN OTHER_____