ORR MEMORY CLINIC
AUTHORIZATION TO DISCLOSE INFORMATION
2308 Ford Parkway, #417 St. Paul, MN 55116 Phone: (651)-528-8183 Fax: (651)-528-8184

Patient's Full Name: _____ Date of Birth: ___ /___ /____

Address: _____

I authorize The Orr Memory Clinic to:

☐ Release to: ☐ Receive from:

| | | | |
|---|---|---|---|
| Person | | Medical Records | |
| Agency | | Agency | |
| Address | | Address | |
| Phone/Fax | | Phone/Fax | |

**Information to be Released**:
☐ Verbal
☐ Clinic visit notes ☐ On-going for care coordination
☐ Medication Information
☐ Other _____

**Records to be Received**:
☐ History and Physical Exams ☐ Discharge Summaries
☐ Consultations/Follow up notes ☐ Clinic visit notes
☐ Medication Information ☐ Lab reports
☐ Neuropsychological report ☐ Cognitive testing
☐ Brain imaging report ☐ Brain imaging film/CD
☐ Other

Dates of Information to be Released:
☐ All ☐ Other _____

Dates of Information to be Obtained:
☐ All ☐ Other _____

☐ Fax records to The Orr Memory Clinic FAX: (651)-528-8184 PHONE: 651-528-8183

☐ Mail records to The Orr Memory Clinic, 2308 Ford Parkway, #417, St. Paul, MN 55116

Reason for Disclosure

☐ Continuing Care ☐ At my Request ☐ Insurance ☐ Disability ☐ Litigation

I release the above-named healthcare provider from all legal responsibility and / or liability that may arise from the release of the records I have specified. I understand that when the specified health information is sent to the receiving agency, the information could be re-disclosed by the agency that receives it and may no longer be protected by federal or state privacy laws. I understand that this authorization can be cancelled by me in writing at any time. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
☐ This release is effective while I am receiving care at Orr Memory Clinic unless I cancel it.

Patient Signature: _____ Date: _____
Guardian Signature (if applicable): _____ Date: _____
Relationship to patient: _____
Reason patient is unable to sign: _____

A photocopy of this release is as valid as the original