

**AMBULATORY EEG RECORDINGS, LLC
AUTHORIZATION FOR DISCLOSURE OF HEALTH
INFORMATION**

Patient Name _____
Date of Birth _____ Telephone Number _____
Address _____
City, State, Zip _____

Releasing Clinic Notes from:

10325 N. Port Washington Rd.
Suite 150
Mequon, WI 53092
Office: 262 241-1701
Fax: 262 241-1801

Copy of Clinic notes to be sent to:

Physician/Insurance Provider/Other – (Please circle response and provide address)

Copy of Clinic notes to be received by:

Patient/Family/Guardian – (Please circle response and provide address)

This authorization is for the sole purpose of disclosing your protected health information to the designated recipient listed above. Signing this authorization is not a condition of treatment. You may end this authorization at any time.

I have had the chance to read this authorization form and agree with the statements listed above. I understand that by signing this form, I am confirming my authorization for disclosure the protected health information described in this form with the organizations/individuals named in this form.

Signature _____ Date _____

If signed by a representative of the individual patient:

Representative's name (print): _____
(signature): _____
(relationship): _____