NEUROTECH©®
EEG Specialists

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Alternate Phone: (_____) _____

Releasing Patient Medical Records From:
Neurotech, LLC
626 W. Moreland Blvd
Waukesha, WI 53188

What are you requesting?

- ☐ Access to EEG Data (Personal ID, password and software link will be provided)
  * There is a $20 fee for providing access to your EEG data
- ☐ Copy of EEG report
  * No additional fee

Who would you like the above information sent to?

- ☐ Patient
- ☐ Family Member — Family Member Name: _____
- ☐ Physician — Physician Name: _____

How would you like the information sent?

- ☐ Email — Email Address: _____
- ☐ Mail — Mailing Address: _____
  _____
  _____

This authorization is for the sole purpose of releasing 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 of Patient/Authorized Representative Date

_____ _____
Print Name Relationship of Representative

**Please allow 7 – 10 business days to receive access to your EEG data.*