CONSENT FOR RELEASE OF INFORMATION

WE CARE ARMHS

PATIENT NAME: ____ **DOB:** ________________

SOCIAL SECURITY # _____________________________________

DATES REQUESTED: ____

INFORMATION REQUESTED:

( ) CLIENT SUMMARY
( ) PROGRESS NOTES
( ) INTAKE
( ) TREATMENT PLAN
( ) PSYCHIATRIC NOTES
( ) MEDICATIONS
( ) DISCHARGE SUMMARY
( ) TELEPHONE CONSULTATION
( ) ALL RECORDS
( ) OTHER ____

INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

( ) CONTINUING CARE
( ) PERSONAL
( ) LEGAL
( ) INSURANCE PAYMENT
( ) INSURANCE APPLICATION
( ) DISABILITY DETERMINATION
( ) OTHER, PLEASE EXPLAIN: ____

ALL RECORDS PERTAINING TO MENTAL HEALTH/CHEMICAL DEPENDENCY/DRUG OR ALCOHOL ABUSE OR HIV RELATED ILLNESSES AND TREATMENT RECORDS WILL BE RELEASED UNLESS INDICATED HERE:

( ) DO NOT RELEASE RECORDS RELATED TO ANY OF THE PREVIOUSLY LISTED INFORMATION

INFORMATION ( ) RELEASED TO ( ) EXCHANGED WITH ( ) OBTAINED FROM:

NAME ____

(PERSON, HOSPITAL, FACILITY, ATTORNEY, ETC…)

ADDRESS ____

CITY/STATE/ZIP ____

PHONE: ______________________________________ **FAX:** _____________________________________

I understand this information will be disclosed to the above person, organization, or agency from records whose confidentiality is protected by Federal Laws (42 CFR Part 2) and by Minnesota Statutes. I also understand that I may revoke this authorization at any time by giving written notice to the Associated Clinic of Psychology, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire one year from the date of signing.

I understand that my clinician generally may not condition psychological/psychiatric services upon my signing an authorization unless the psychological/psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

SIGNATURE OF CLIENT: ____ **DATE** __________

SIGNATURE OF PARENT OR GUARDIAN (*if applicable*) ___________________________ **RELATIONSHIP** __________

IF PATIENT IS UNABLE TO SIGN, REASON: ____