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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Name of client) (Date of Birth)

I authorize _____ at **Psychotherapeutic Resources**
325 North 33rd Avenue, Suite 103, St. Cloud, MN 56303 (fax: 320-252-2567) to:

() obtain information from () disclose information to () exchange information with

Name:: _____

Address: _____

This information is needed for:

___ Treatment continuity ___ Treatment consultation/coordination ___ Client's request
___ Other: _____

Dates of service requested:

Present episode of care Past 7 years of medical records
 Specific dates or years of treatment _____

Initial below the specific information to be disclosed:

- () Social/Psychological/Psychiatric Assessment () School Records
- () Progress Notes () Psychological Testing
- () Diagnosis () Summary of Treatment Contacts
- () Dates of Treatment () Discharge Summary
- () Treatment Plan () All Health Information
- () Other (please specify): _____

Specifically, the following is requested: () Chemical Dependency Treatment/Evaluation from a Chemical Dependency Program.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date ___/___/___ Or specific event _____

I understand I may revoke this authorization in writing at any time by sending such written notification to the above office address. However, my revocation will be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that providers generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

A photocopy is valid as the original bearing my signature.

(Signature of client) (Date)

(or Legal/Personal representative) (By What Authority) (Date)