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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

____ ______________
(Name of client) (Date of Birth)

I authorize _______________________________ at **Psychotherapeutic Resources**
1411 W Saint Germain St, Ste 105, St. Cloud, MN 56301 (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
( ) Progress Notes
( ) Diagnosis
( ) Dates of Treatment
( ) Treatment Plan
( ) School Records
( ) Psychological Testing
( ) Summary of Treatment Contacts
( ) Discharge Summary
( ) 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)