

PATIENT AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

<input type="checkbox"/> 3100 West Lake St, Suite #210, Minneapolis, MN 55416 <input type="checkbox"/> 6950 West 146th St, Suite #100, Apple Valley, MN 55124 <input type="checkbox"/> 149 Thompson Ave E, Suite #150, West St. Paul, MN 55118 <input type="checkbox"/> 6200 Shingle Creek Pkwy, Suite #350, Brooklyn Center, MN 55430 <input type="checkbox"/> 450 Syndicate St. South, #385, St. Paul, MN 55104 <input type="checkbox"/> 1155 Ford Rd, Suite B, St. Louis Park, MN 55426	Ph: 612-925-6033 Ph: 952-432-1484 Ph: 651-450-0860 Ph: 763-503-8560 Ph: 612-925-6033 Ph: 952-378-1800	Fax: 612-925-8496 Fax: 952-432-2328 Fax: 651-450-0759 Fax: 763-503-8563 Fax: 612-925-8496 Fax: 952-378-1714
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PATIENT INFORMATION	PATIENT NAME: _____ DOB: _____ PREVIOUS LAST NAME: _____ ACP ACCT #: _____
TYPE OF RELEASE <i>(you may select one or both)</i>	<input type="checkbox"/> Written <input type="checkbox"/> Verbal
HEALTH INFORMATION RELEASE <i>(you may select one or both)</i>	<input type="checkbox"/> I authorize Associated Clinic of Psychology to RECEIVE information FROM: <input type="checkbox"/> I authorize Associated Clinic of Psychology to RELEASE information TO: NAME: _____ (PERSON, HOSPITAL, FACILITY, ATTORNEY, ETC...) ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ PHONE: _____ FAX: _____
INFORMATION TO BE RELEASED <i>(you may select more than one)</i>	DATE(S) OF SERVICE(S): From: _____ To: _____ <input type="checkbox"/> all dates (check here) <input type="checkbox"/> PROGRESS NOTES <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> INTAKE <input type="checkbox"/> PSYCHIATRIC NOTES <input type="checkbox"/> TREATMENT PLAN <input type="checkbox"/> TELEPHONE CONSULTATION <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> TEST RESULTS/EVALUATION <input type="checkbox"/> ALL RECORDS <input type="checkbox"/> OTHER: _____
PURPOSE OF RELEASE	<input type="checkbox"/> CONTINUATION OF CARE <input type="checkbox"/> INSURANCE PAYMENT <input type="checkbox"/> PERSONAL <input type="checkbox"/> LEGAL <input type="checkbox"/> INSURANCE <input type="checkbox"/> DISABILITY DETERMINATION <input type="checkbox"/> OTHER _____ <i>*Fees may be charged based on MN State and Federal Regulations</i>
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: <input type="checkbox"/> DO NOT RELEASE RECORDS RELATED TO ANY OF THE PREVIOUSLY LISTED INFORMATION	
<p><i>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></p> <p><i>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.</i></p>	

SIGNATURE OF PATIENT: _____ **DATE:** _____

SIGNATURE OF PARENT/GUARDIAN (if applicable): _____ **DATE:** _____

IF PATIENT IS UNABLE TO SIGN, REASON: _____