ASSOCIATED CLINIC OF PSYCHOLOGY

PATIENT AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

☐	3100 West Lake St. Suite #210 Minneapolis, MN 55416	Ph: 612-925-6033	Fax: 612-925-8496
☐	6950 West 146th St. Suite #100 Apple Valley, MN 55124	Ph: 952-432-1484	Fax: 952-432-2328
☐	1633 South Robert St. Suite A West St. Paul, MN 55118	Ph: 651-450-0860	Fax: 651-450-0759
☐	6200 Shingle Creek Pkwy Suite #350 Brooklyn Center, MN 55430	Ph: 763-503-8560	Fax: 763-503-8563
☐	450 Syndicate St South #385 St. Paul, MN 55104	Ph: 612-925-6033	Fax: 612-925-8496
☐	1155 Ford Rd Suite B St Louis Park, MN 55426	Ph: 952-378-1800	Fax: 952-378-1714

PATIENT INFORMATION

PATIENT NAME: _____ DOB:_____

PREVIOUS LAST NAME: _____ ACP ACCT #:_____

TYPE OF RELEASE *(you may select one or both)*

☐ Written ☐ Verbal

HEALTH INFORMATION RELEASE *(you may select one or both)*

☐ I authorize Associated Clinic of Psychology to RECEIVE information FROM:
☐ 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 *(you may select more than one)*

DATE(S) OF SERVICE(S): From: _____ To: _____ ☐ all dates (check here)

☐ PROGRESS NOTES	☐ MEDICATIONS
☐ INTAKE	☐ PSYCHIATRIC NOTES
☐ TREATMENT PLAN	☐ TELEPHONE CONSULTATION
☐ DISCHARGE SUMMARY	☐ TEST RESULTS/EVALUATION
☐ ALL RECORDS	☐ OTHER: _____

PURPOSE OF RELEASE

☐ CONTINUATION OF CARE	☐ INSURANCE PAYMENT
☐ PERSONAL	☐ LEGAL
☐ INSURANCE	☐ DISABILITY DETERMINATION
☐ OTHER_____	

**Fees may be charged based on MN State and Federal Regulations*

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

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 PATIENT: _____ DATE: _____

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

IF PATIENT IS UNABLE TO SIGN, REASON: _____