

MINNESOTA PSYCHOLOGICAL RESOURCES

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____	Client ID # _____	
Previous Names _____	SS# _____ - _____ - _____	DOB ____/____/____
Phone Numbers (Home) _____	(Work) _____	(Other) _____

This authorizes Minnesota Psychological Resources to request information from:
(and/or)

This authorizes Minnesota Psychological Resources to release records to:

Name/Organization _____
Street Address _____
City _____ State _____ Zip _____

Please release the following information (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Hospital /Clinic Notes | <input type="checkbox"/> Psychological Testing- Interpretation |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Diagnosis | _____ |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Psychological Testing- Raw Data | _____ |

For the following date(s) of treatment or condition: _____
(specify dates of treatment or condition)

This information release is being requested for the following purpose:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Diagnosis & Evaluation | <input type="checkbox"/> Treatment Coordination & Planning | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Continued care by another provider | <input type="checkbox"/> Insurance claim purposes | <input type="checkbox"/> Other _____ |

- All records pertaining to psychiatric/ mental health, chemical dependency and/or AIDS/HIV related illness/ testing will be released unless otherwise indicated by a checkmark here: _____
Please indicate any restrictions. (Specify) _____
- I understand I may revoke this authorization by written request at any time to the address checked at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
_____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge assigned with the release.
- I understand that once information is released pursuant to this authorization, Minnesota Psychological Resources can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Minnesota Psychological Resources will not condition treatment on my signing this authorization.

Signature of Patient/ Authorized Person
(If authorized person is signing, please also print name)

Authorized Person's authority to sign **Date**
(Parent, Guardian, Power of Attorney, etc.)

Reason patient is unable to sign: Minor Deceased Other: _____