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Mankato Mental Health Associates, P.A.
201 North Broad Street, Suite 308
Mankato, MN 56001

(507) 508-9278
Medication Management

CONSENT FOR THE RELEASE OF INFORMATION

Patient Name_____ **Date of Birth**_____
Address_____
City_____ **State**_____ **Zip**_____
Home Phone_____ **Cell Phone**_____

I am requesting that my health information be: □ **Exchanged With** □ **Released To** □ **Obtained From**

Name_____ **Relationship to Client**_____
Facility Name_____
Address_____
City_____ **State**_____ **Zip**_____
Phone_____ **Fax**_____
Reason for release of information_____

Please check information to be released and indicate the dates of service to be included_____

- □ Evaluations/Assessments including Diagnostic, Psychiatric, Psychological, Medical, Chemical Dependency
- □ Psychotherapy Notes
- □ Psychological Testing/Neuropsychological Testing Results
- □ Chemical Dependency Treatment Summary/Discharge Summary
- □ Facility Admission Summary/Discharge Summary/History and Physical
- □ Primary Care Office Visit Notes
- □ Laboratory and EKG Reports
- □ Current Medication List (and historical medication trials when available)
- □ Human Services Agency Records/Information
- □ Court/Corrections Records/Information
- □ School or Educational Records/Information
- □ Other_____

I have been instructed as to the information to be released, the purpose and intended use of the released information, who will receive the information, and any known consequences of this release. The information to be released is private and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn. Stat. 1982 Chap. 13).

I understand that State and Federal privacy laws protect my records. My records can be released only if I give written permission or if the law allows it. I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. Further, I realize that Mankato Mental Health Associates, P.A., cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections, therefore Mankato Mental Health Associates, P.A., is released from any and all liability resulting from re-disclosure.

I have the right to revoke this authorization at any time by giving written notice to Mankato Mental Health Associates, P.A. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire one year after the date of my signature. I understand that the revocation will not apply to information that has already been released in response to this authorization, nor will it apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

This authorization WILL permit two-way communication via face-to-face, telephone, and electronic methods of information exchange.

I am entitled to a copy of this authorization once I have signed it. A photograph or facsimile of this authorization is as effective as the original.

I have been informed of my right to refuse to release this information.

Date, event, or condition upon which this consent expires_____

_____ _____
Client or Authorized Signature **Date**

_____ _____
Witness Signature **Date**