Consent Form to Release Protected Health Information

1 Patient information

First name _____ Middle Name _____ Last name_____

Date of birth _____/_____/_____ Previous name(s) _____

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ Email address (optional) _____

2 I am requesting that health information be sent to or received from

Organization(s) name _____

And/Or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

Information needed by (date) _____/_____/_____ (optional)

3 How information is to be released

- ❑ Verbally
- ❑ In writing
- ❑ Both

4 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

- ❑ Specific dates of treatment _____
- ❑ **All records**

OR to only release specific portions of your (mental) health information, indicate the categories to be released:

- ❑ Diagnostic assessments (intake)
- ❑ Progress notes
- ❑ Treatment plans
- ❑ Discharge/termination notes

- ❑ Psychological assessment
- ❑ Psychiatric evaluation
- ❑ Testing results
- ❑ Case records
- ❑ School records
- ❑ Other _____

★ For chemical dependency assessments or psychotherapy notes, an additional addendum is needed.

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5 Reason(s) for releasing information

- ❑ Client request
- ❑ Review client's current care
- ❑ Treatment/continued care
- ❑ Payment
- ❑ Insurance application
- ❑ Legal
- ❑ Appeal denial of Social Security Disability income of benefits
- ❑ Other (please explain) _____

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6 I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent/exchanged to the third party named in section 2.

- I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2.
- If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information.
- I understand that when the health information specified in section 4 is sent to the third party named in section 2, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
- I understand that if the organization named in section 2 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This consent will end one year from the date this form is signed unless I indicate here (mark and initial):

- ❑ Keep consent valid until treatment termination at Serenity Circle Counseling. _____ initial here

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7 Patient's signature_____Date _____

OR legally authorized representative's signature_____Date _____

Representative's relationship to the client (parent, guardian, etc.)_____

Fax 763-244-1243 or Mail to: Serenity Circle Counseling, PO Box 23, Isanti, MN 55040