Shoreview Mental Health Center
5985 Rice Creek Blvd, Suite 201
Shoreview, MN 55126
Phone: (651) 348-7240
Fax: (651) 348-7265

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Information:

______________________________ Patient Name/Previous Name

______________________________ Date of Birth

______________________________ Street Address

______________________________ Daytime Phone

______________________________ City, State, Zip

I request and authorize Shoreview Mental Health Center (________________________________) to
Therapist/Provider Name and Credentials, if known

☐ *Release Information to:* or ☐ *Request Information From:*

______________________________ Name of Person/Institution/Agency/Clinic/Facility/Company/Firm

______________________________ Phone Number

______________________________ Street Address

______________________________ Fax Number

______________________________ City, State, Zip

This request and authorization applies to:

☐ Complete Record ☐ Current Diagnostic Assessment ☐ Test Results ☐ Discharge Summary
☐ Specific dates, treatments, or services: ________________________________
☐ Other (specify): ____

Purpose of Disclosure: ____

I understand the consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in compliance of this consent. If revocation is not received, authorization will be considered valid for a period of one year from date the ROI was attained. The facility, its employees, officers, and attending providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized. I understand that the information released could contain reference to Substance Abuse, Psychological and/or Psychiatric Impairment.

To the party receiving this information: this information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART2.

Client Signature: ____ Date: ______________

Guardian Signature: ______________________________________ Date: ______________

Relationship to Client: ____