Mears Psychological LLC
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Patient Authorization to Release/Discloser Health Information

PATIENT INFORMATION

PATIENT NAME:	#PatientName	**DOB:**	#PatientDoB
PREVIOUS LAST NAME:		TSA ACCT #:	

TYPE OF RELEASE

(you may select one or both) ☐ Written ☐ Verbal

HEALTH INFORMATION RELEASE

(you may select one or both)

☐ I authorize The Soul's Apothecary to RECEIVE information FROM:

☐ I authorize The Soul's Apothecary 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

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

☐ OTHER:

PURPOSE OF RELEASE

☐ CONTINUATION OF CARE ☐ PERSONAL ☐ INSURANCE ☐ INSURANCE PAYMENT ☐ LEGAL ☐ 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:

DATE: #CurrentDate

SIGNATURE OF PARENT/GUARDIAN (if applicable)

DATE: #CurrentDate

IF PATIENT IS UNABLE TO SIGN, REASON: