**Release of Information Authorization**

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**Client Information**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Authorize the Release of Information To/From:**

* **Name/Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Release **TO** this person/agency  
☐ Receive **FROM** this person/agency  
☐ Mutual exchange of information

**Information to Be Released (check all that apply):**

☐ Intake/Assessment  
☐ Treatment Plan  
☐ Progress Notes  
☐ Medication Records  
☐ Psychiatric Evaluation  
☐ Psychological Testing  
☐ Attendance Records  
☐ Billing/Insurance  
☐ Discharge Summary  
☐ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure (check all that apply):**

☐ Continuity of Care  
☐ Legal  
☐ Disability/Benefits  
☐ Personal Use  
☐ School  
☐ Insurance  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization Terms**

* This authorization is valid until: \_\_\_ / \_\_\_ / \_\_\_\_\_\_ (cannot exceed 1 year)
* I understand that I may revoke this authorization at any time in writing, except where information has already been released based on prior consent.
* I understand that authorizing this release is voluntary.
* I understand that the information disclosed may include sensitive data such as mental health, substance use, or HIV-related information, and I give my specific consent to share such information as indicated above.

**Signature**

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_\_  
**Parent/Guardian (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_  
**Witness Signature (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_\_