Hope & Outreach Therapy Services, LLC
Business Mailing Address: 1255 Danforth Street, St. Paul, MN 55117
Direct: 651-605-6370
Email Address: kylie@hopeandoutreach.com

CONSENT TO RELEASE - Mental Health Records

I, _______________________________, BIRTH DATE ____/____/____, Hereby authorize Hope & Outreach Therapy Services, LLC, to have bilateral exchange of information that is contained in my medical record with: _______________
Address/Contact#/Fax#:
____
____
under the conditions listed below:

1. This information will be limited to:
   ____ Mental Health Evaluation
   ____ Progress notes.
   ____ Psychotherapy notes.
   ____ Lab studies
   ____ Medical tests/studies.
   ____Psychological testing.
   ____Educational testing.
   ____Other:
   ____Other:

2. Purpose or need for such disclosure: ______ Continuing care/ Treatment, and/or ____________________________________
   ____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _________

____.

(Specific Date, Event or Condition – 1 year from signed date if not filled in)

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

____________________________________ Patient's Signature	__________________ Date
____________________________________ Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Indicate which.	__________________ Date
____________________________________ Witness (if applicable)	__________________ Date