**Reflections Mental Health**

410 Luella Street, Watkins, MN 55389

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**AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION** I Authorize: Lynette (Lyn) Imdieke-Struzyk

Patient Information: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Previous Name (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

**AT**: Reflections Mental Health, 410 Luella Street, Watkins, MN 55389

 Any and All Medical and Mental Records

 All records dated from \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_

 Verbal

OR Only release the records checked below

 Most Recent Progress Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Assessment Diagnostic Form, 3 most recent Progress Notes and Treatment Plan

 Psychological Testing Interpretive Report

 Itemized billing statement \*

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

.

Information to be Released:

(What do you want sent or released?)

Check the appropriate box(s).

To do the following:

 Release to

 Receive from

 Both

Agency/ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And All staff /or Person: (First/ Last name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Purpose of Release

(Why is it needed?)

Check the appropriate box(s).

SPECIAL NOTE: Mentalhealth information, alcohol/ drug abuse information and AIDS related illness

information appearing in any of the records/information selected above will be disclosed unless indicated

 otherwise below.

 Do not release records/information related to mental health, alcohol/drug abuse or AIDS related illness

 Coordination of care  Personal use or review  Other:

 Social Security Appeal  Social Security Disability

 Insurance payment/claim  Litigation/ Legal

I understand that by signing this form, I am requesting that the health information specified in section “Information to be released” be sent to the third party named in section “To do the following”. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section “I Authorize”. If the organization, facility or professional named in section “I Authorize” 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 “Information to be released” is sent to the third party named in section “To do the following”, 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 “To do the following” is a health care provider they will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named in section “To do the following” is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

**This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:**

Date (MM)\_\_\_\_\_\_ / (DD)\_\_\_\_\_ / (YYYY)\_\_\_\_\_\_\_\_ Or specific event

**Patient’s signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (MM) \_\_\_\_ /(DD) \_\_\_ /(YYYY)\_\_\_\_\_\_

**OR**

**Legally authorized representative’s signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_

**Representative’s relationship to patient (parent, guardian, etc.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NOTE: If signed by someone other than the patient, we need written proof of your authority.

**\*\*\*\*DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT**

Reflections-Release of information.doc