Heartstrings Counseling
Healing Hearts, Healing Families

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CONSENT FOR RELEASE OF PRIVATE INFORMATION

NAME OF CLIENT: _____ DOB: _____

STREET ADDRESS: _____

AUTHORIZE THE RELEASE AND/OR EXCHANGE OF THE FOLLOWING INFORMATION FROM MY RECORDS (PLEASE CHECK ALL THAT APPLY)

_____DIAGNOSTIC ASSESSMENT
_____PROGRESS NOTES
_____ALL MEDICAL RECORDS
_____DISCHARGE TREATMENT SUMMARIES
_____VERBAL COMMUNICATION (PHONE
_____LEGAL/POLICE RECORDS/INCIDENT REPORTS
_____SUMMARY OF SOCIAL HISTORY
_____COURT DOCUMENTATION/INVESTIGATIONS/LETTERS/ REPORTS / AFFIDAVITS
_____CHEMICAL DEPENDENCY TREATMENT/EVALUATION
_____PSYCHIATRIC EVALUATION AND MEDICATION MANAGEMENT RECORDS
_____ DIAGNOSIS
_____PSYCHOLOGICAL TEST SCORES / PROFILES
_____ PROGRESS REPORTS / TREAMENT PLAN
_____ DIAGNOSIS
_____ CHILD ABUSE/NEGLECT ASSESSMENT REPORTS

THIS INFORMATION IS FOR TREATMENT PLANNING AND CASE CONSULTATION

THIS CONSENT WILL EXPIRE WITHIN ONE YEAR FROM THE DATE OF SIGNATURE UNLESS EARLIER EXPIRATION IS NOTED HERE _____.

THIS INFORMATION WILL BE EXCHANGED BETWEEN (TO/FROM)
HEARTSTRINGS COUNSELING, 14400 BURNSVILLE PARKWAY, BURNSVILLE, MN 55337 AND

PERSON/ORGANIZATION: _____
ADDRESS: _____
PHONE NUMBER: _____ FAX NUMBER: _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME WITH WRITTEN NOTIFICATION, BUT THAT THE REVOCATION WILL NOT HAVE ANY EFFECT ON THE INFORMATION RELEASED PRIOR TO NOTIFICATION OF REVOCATION. PLEASE SEE YOUR NOTICE OF PRIVACY PRACTICES FOR INFORMATION ON HOW TO REVOKE THIS AUTHORIZATION. A PHOTOCOPY/FAX OF HTIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS THE ORIGINAL.

HEARTSTRINGS COUNSELING CANNOT PREVENT THE FURTHER DISCLOSURE OF RECORDS RELEASED AS A RESULT OF THIS REQUEST AND THAT THE RECORDS MAY NOT BE SUBJECT TO PRIVACY RULE PROTECTIONS; THEREFORE HEARTSTRINGS COUNSELING IS RELEASED FROM ANY OR ALL LIABILITY RESULTING FROM RE-DISCLOSURE FROM 3RD PARTY SOURCES.

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO DISCLOSURE RECIPIENT OF YOUR INFORMATION AND NO LONGER PROTECTED BY HIPPA PRIVACY RULE.

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATED TO SEXUALLY TRANSMITTED DISEASES, AIDS, OR HIV. IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES AND TREATMENT FOR ALCOHOL/DRUG USE.

MY SIGNATURE ALSO MEANS THAT I HAVE READ THIS FORM AND/OR HAVE HAD IT READ TO ME AND EXPLAINED IN A LANGUAGE THAT I CAN UNDERSTAND.

CLIENT SIGNATURE; _____Date _____

CLIENT SIGNATURE: _____Date _____

THERAPIST SIGNATURE _____Date _____