CHIME MENTAL HEALTH SERVICES
COURAGE HAPPINESS INTEGRITY MINDFULNESS EMPATHY

Chime Mental Health Services
46 S Broadway
Wells, MN 56097

Phone (507) 461-0874
www.chimementalhealth.com

Consent for the Release of Information

Patient Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Primary Phone _____ Secondary Phone_____

I am requesting that my health information be: ▫ Exchanged With ▫ Released To ▫ Obtained From

Name_____ Relationship to Client_____

Facility Name _____

Address_____City_____State_____ Zip_____

Phone_____ Fax_____

Reason for release of information_____

Please check information to be released and indicate the dates of service to be included

- ☐ Evaluations/Assessments - Diagnostic, Psychiatric, Psychological, Medical, Chemical Dependency
- ☐ Psychotherapy Notes ▫ Psychological Testing/Neuropsychological Testing Results
- ☐ Chemical Dependency Treatment Summary/Discharge Summary
- ☐ Facility Admission Summary/Discharge Summary/History and Physical
- ☐ Primary Care Office Visit Notes ▫ Laboratory and EKG Reports
- ☐ Current Medication List (and historical medication trials when available)
- ☐ Human Services Agency Records/Information ▫ Court/Corrections Records/Information
- ☐ School or Educational Records/Information
- ☐ Other_____

I have been instructed as to the information to be released, the purpose and intended use of the released information, who will receive the information, and any known consequences of this release. The information to be released is private and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn. Stat. 1982 Chap. 13).

I understand that State and Federal privacy laws protect my records. My records can be released only if I give written permission or if the law allows it. I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. Further, I realize that Chime Mental Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections, therefore Chime Mental Health Services is released from any and all liability resulting from redisclosure.

I have the right to revoke this authorization at any time by giving written notice to Chime Mental Health Associates. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire one year after the date of my signature. I understand that the revocation will not apply to information that has already been released in response to this authorization, nor will it apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

This authorization WILL permit two-way communication via face-to-face, telephone, and electronic methods of information exchange. I am entitled to a copy of this authorization once I have signed it. A photograph or facsimile of this authorization is as effective as the original. I have been informed of my right to refuse to release this information.

This form expires one year from the date it was signed.

_____ _____

Client or Authorized Signature Date

_____ _____

Witness Signature Date