



Chime Mental Health Services Therapy & ARMHS

(507) 461-0874 (call or text)

126 South Broadway Wells, MN 56097

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 United South Central Staff Relationship to Client School

Facility Name United South Central School

Address 600 11th St South West City Wells State MN Zip 56097

Phone 507-553-5819 Fax _____

Reason for release of information Collaborate Treatment

Please check the 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 are 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