MINNESOTA PSYCHOLOGICAL RESOURCES

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Pequot Lakes, MN 56472-0413
218-568-4500 phone
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name_____ Client ID # _____

Previous Names_____ SS#_____-_____-_____ DOB___/___/____

Phone Numbers (Home)_____(Work)_____(Other)_____

☐ **This authorizes Minnesota Psychological Resources to request information from:**
(and/or)
☐ **This authorizes Minnesota Psychological Resources to release records to:**

Name/Organization_____

Street Address_____

City_____State_____Zip_____

Please release the following information (check all that apply):

☐ Admission Summary
☐ Discharge Summary
☐ History and Physical Exam
☐ Consultation Reports
☐ Hospital /Clinic Notes
☐ Treatment Summary
☐ Diagnosis
☐ Psychological Testing- Raw Data
☐ Psychological Testing- Interpretation
☐ Other (specify)_____
_____

For the following date(s) of treatment or condition: _____
(specify dates of treatment or condition)

This information release is being requested for the following purpose:

☐ Diagnosis & Evaluation
☐ Continued care by another provider
☐ Treatment Coordination & Planning
☐ Insurance claim purposes
☐ Personal use
☐ Other_____

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____
  Please indicate any restrictions. (Specify)_____
- I understand I may revoke this authorization by written request at any time to the address checked at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, unless a different expiration date is specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge assigned with the release.
- I understand that once information is released pursuant to this authorization, Minnesota Psychological Resources can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Minnesota Psychological Resources will not condition treatment on my signing this authorization.

_____ _____ _____

Signature of Patient/Authorized Person
(If authorized person is signing, please also print name)

Authorized Person's Authority to Sign
(Parent, Guardian, Power of Attorney, etc.)

Date

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____