ACP ASSOCIATED CLINIC OF PSYCHOLOGY

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION TO PRIMARY CARE PROVIDER

1 Client Information

First and Last Name _____ **Client Date of Birth** _____

Previous Name(s) _____

Home Address _____

Phone_____ Secondary Phone: _____

2 This form when completed and signed by you, authorizes ACP to release protected personal health information to your primary care physician and/or clinic for continuity of care purposes, unless you choose to opt out below.

Check *one* of the boxes listed below.

☐ I **do not have OR do not authorize** ACP to contact my primary care physician or clinic.

☐ I **authorize** ACP to exchange information with my primary care physician and/or clinic.

Physician Name (if known): _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone: _____ Clinic Fax: _____

3 Information to be released. IMPORTANT: Indicate only the information you are authorizing to be released. By checking any of the boxes below, you authorize mental health records to be released.

☐ Care Coordination Package (*includes Diagnostic Assessment, Treatment plan, last two progress notes, and discharge if applicable*)

☐ Intake/Diagnostic Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary

☐ Psychiatric Notes ☐ Telephone Consultation ☐ Test Results/Evaluation ☐ Medication List

☐ Other (please specify): _____

AND please indicate date span below (if none indicated, intake and last two visit notes will be released):

☐ Specific Dates _____

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ACP ASSOCIATED CLINIC OF PSYCHOLOGY

Patient's Name _____ **Date of Birth** _____

4 Health information includes written and oral information

By indicating that you authorize ACP to contact your primary care physician or clinic in section 2, you are giving permission for written information to be released and for ACP to talk to a person in section 2 about your health information.

If you do not want to give your permission for ACP to talk with your primary care physician or clinic about your health information, indicate that here (check mark or initials) _____. If checked, only written records will be shared.

5

I understand this information will be disclosed to the above person, organization, or agency from records whose confidentiality is protected by Federal Laws (42 CFR Part 2) and by Minnesota Statutes. I also understand that I may revoke this authorization at any time by giving written notice to the Associated Clinic of Psychology, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire three years from the date of signing. I understand that treatment by any party may not be conditioned upon my signing this authorization unless the psychological/psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. All records pertaining to chemical dependency/drug or alcohol abuse, or HIV related illnesses and treatment records will be released unless indicated here by your initials: _____

6 Client's Signature _____ Date _____

OR Parent/Guardian Signature _____ Date _____

Parent/Guardian (printed name): _____

Representative's relationship to client (parent, guardian, etc.) _____

PLEASE NOTE: ACP requires supporting documentation in cases where guardianship or legal custody are involved, prior to release of protected health information.

This authorization will expire in 3 years from the date of signature. Releases of Information signed by parent/guardian for a minor will expire in 3 years, or on client's 18th birthday, whichever date comes sooner.

ACP Clinic Locations

☐ ACP Minneapolis: 4027 County Road 25, Minneapolis, MN 55416	PH: 612-925-6033	FAX: 612-925-8496
☐ ACP Apple Valley: 6950 West 146th Street, Suite 100, Apple Valley, MN 55124	PH: 952-432-1484	FAX: 952-432-2328
☐ ACP West St. Paul: 149 Thompson Avenue E, Suite 150, West St. Paul, MN 55118	PH: 651-450-0860	FAX: 651-450-0759
☐ ACP Brooklyn Center: 6200 Shingle Creek Parkway, Suite 350, Brooklyn Center, MN 55430	PH: 763-503-8560	FAX: 763-503-8563
☐ ACP West Metro: 1155 Ford Road, Suite B, St. Louis Park, MN 55426	PH: 952-378-1800	FAX: 952-378-1714
☐ ACP St. Paul Midway: 450 Syndicate Street N, Suite 385, St. Paul, MN 55104	PH: 612-925-6033	FAX: 612-925-8496
☐ ACP Hudson: 2501 Hanley Road, Suite 101, Hudson, WI 54016	PH: 715-954-5300	FAX: 612-925-8496