Client ID # _____

ASSOCIATED CLINIC OF PSYCHOLOGY

☐ 4027 County Road 25, Minneapolis, MN 55416	Ph: 612-925-6033	Fax#: 612-925-8496
☐ 6950 West 146th St, Suite 100, Apple Valley, MN 55124	Ph: 952-432-1484	Fax#: 952-432-2328
☐ 149 Thompson Ave East, Suite 150, West St. Paul, MN 55118	Ph: 651-450-0860	Fax#: 651-450-0759
☐ 6200 Shingle Creek Parkway, Suite 350, Brooklyn Center, MN 55430	Ph: 763-503-8560	Fax#: 763-503-8563
☐ 450 Syndicate St North, Suite 385, St. Paul, MN 55104	Ph: 612-925-6033	Fax#: 612-925-8496
☐ 1155 Ford Road, Suite B, St. Louis Park, MN 55426	Ph: 952-378-1800	Fax#: 952-378-1714

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION TO A PRIMARY CARE PHYSICIAN

_____ ____/____/____

Client Name (please print) **Date of Birth**

THIS FORM WHEN COMPLETED AND SIGNED BY YOU, AUTHORIZES ACP TO RELEASE PROTECTED PERSONAL HEALTH INFORMATION TO YOUR PRIMARY CARE PHYSICIAN FOR CONTINUITY OF CARE PURPOSES.

*Check ***one*** of the boxes listed below.

☐ *I **do not have** a primary care physician.*

☐ *I **do not authorize** ACP to contact my primary care physician.*

☐ *I **authorize** ACP to exchange information with my primary care physician.*

PHYSICIAN NAME: _____

CLINIC NAME: _____

CLINIC ADDRESS: _____

_____

TELEPHONE: _____

FAX: _____

AT THE REQUEST OF THE INDIVIDUAL, THE FOLLOWING INFORMATION IS RELEASED:

Client Summary: This may include any of the following: Medication, Treatment Plan, Discharge Summary.

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 one year from the date of signing.

I understand that my clinician generally may not condition psychological/psychiatric services upon my signing an 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.

SIGNATURE OF CLIENT: _____ *DATE:* _____

SIGNATURE OF PARENT OR GUARDIAN (IF APPLICABLE): _____ *RELATIONSHIP:* _____

IF PATIENT IS UNABLE TO SIGN, REASON: _____

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Client Name: _____ **DOB:** _____

Date of Service: _____

Dear Primary Care Physician:

This letter is to inform you that our mutual client was seen at Associated Clinic of Psychology. Please contact our Medical Records department at the location noted above at your convenience to further coordinate care or with any questions you may have. We look forward to working with you!

Sincerely,

Associated Clinic of Psychology