ASSOCIATED CLINIC OF PSYCHOLOGY

PATIENT AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

☐ 4027 County Road 25, Minneapolis, MN 55416	PH: 612-925-6033	FAX: 612-925-8496
☐ 6950 West 146th Street, Suite 100, Apple Valley, MN 55124	PH: 952-432-1484	FAX: 952-432-2328
☐ 149 Thompson Avenue E, 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
☐ 1155 Ford Road, Suite B, St. Louis Park, MN 55426	PH: 952-378-1800	FAX: 952-378-1714
☐ 450 Syndicate Street N, Suite 385, St. Paul, MN 55104	PH: 612-925-6033	FAX: 612-925-8496
☐ 2501 Hanley Road, Suite 101, Hudson, WI 54016	PH: 715-954-5300	FAX: 612-925-8496

<table>
<tr><td>PATIENT INFORMATION</td><td colspan="2">PATIENT NAME: _____
PREVIOUS LAST NAME: _____</td><td>DOB: _____
ACP ACCT # _____</td></tr>
<tr><td>TYPE OF RELEASE
(select one or both)</td><td colspan="3">☐ Written ☐ Verbal</td></tr>
<tr><td>HEALTH INFORMATION RELEASE
(select one or both)</td><td colspan="3">☐ I authorize Associated Clinic of Psychology to RECEIVE information FROM:
☐ I authorize Associated Clinic of Psychology to RELEASE information TO:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ FAX: _____</td></tr>
<tr><td rowspan="2">INFORMATION TO BE RELEASED
(you may select more than one)</td><td colspan="3">DATES OF SERVICE(S) FROM: _____ TO: _____ ☐ ALL DATES (check here)</td></tr>
<tr><td colspan="2">☐ PROGRESS NOTES
☐ INTAKE
☐ TREATMENT PLAN
☐ DISCHARGE SUMMARY
☐ ALL RECORDS</td><td>☐ MEDICATION LIST
☐ PSYCHIATRIC NOTES
☐ TELEPHONE CONSULTATION
☐ TEST RESULTS / EVALUATION
☐ OTHER: _____</td></tr>
<tr><td>PURPOSE OF RELEASE</td><td colspan="2">☐ CONTINUATION OF CARE
☐ PERSONAL
☐ INSURANCE
☐ OTHER: _____</td><td>☐ INSURANCE PAYMENT
☐ LEGAL
☐ DISABILITY DETERMINATION

*Fees may be charged based on MN State and Federal Regulations</td></tr>
</table>

ALL RECORDS PERTAINING TO MENTAL HEALTH/CHEMICAL DEPENDENCY/DRUG OR ALCOHOL ABUSE OR HIV RELATED ILLNESSES AND TREATMENT RECORDS WILL BE RELEASED UNLESS INDICATED HERE:

☐ DO NOT RELEASE RECORDS RELATED TO ANY OF THE PREVIOUSLY LISTED INFORMATION

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 PATIENT: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN (if applicable): _____ DATE: _____

IF PATIENT IS UNABLE TO SIGN, REASON: _____