ASSOCIATED CLINIC OF PSYCHOLOGY

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

1 Patient Information

First name ______________________ Middle name _______________________ Last name ______________________

Patient date of birth _______________ Previous name(s) ____

Home Address ____

City _______________________________________ State _________________ Zip Code ________________________

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 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.

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ACP ASSOCIATED CLINIC OF PSYCHOLOGY

Patient's Name ____ **Date of Birth** ___________________

4 Information to be released.
IMPORTANT: indicate only the information you are authorizing to be released.

☐ Care Coordination Package (*includes Intake/Diagnostic Assessment, Treatment plan, and most recent progress notes*)

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

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

☐ Other (please specify): ____

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

☐ Specific Dates ____

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 mental health/chemical dependency/drug or alcohol abuse, or HIV related illnesses and treatment records will be released unless indicated here: _______ Initial here to NOT release records related to any of the previously listed information. If you initial here, it will prevent records from being released.

6 Patient's signature ____ Date _______________

OR parent/guardian signature ____ Date _________________

Parent/Guardian (printed name): ____

Representative's relationship to patient (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 date of signature *unless another date is specified*: ____________________
****Please note: Releases of Information signed by parent/guardian for a minor will expire on client's 18th birthday – please list minor's 18th birthday in space provided****

Location	Phone	Fax
☐ 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