ASSOCIATED CLINIC OF PSYCHOLOGY

CLIENT AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1 Client Information

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

Previous Name(s) _____

Home Address _____

Phone_____ Secondary Phone: _____

2 Initial action – What would you like done with the release?

☐ Keep on File (for future use) ☐ Send Records (to name listed below) ☐ Request records (from name listed below)

3 Health Information Release (<u>select one or both</u>):

☐ I authorize Associated Clinic of Psychology to **RECEIVE** information **FROM**:

☐ I authorize Associated Clinic of Psychology to **RELEASE** information **TO**:

Name (person or organization): _____

Address _____

City _____ State _____ Zip Code _____

Phone: _____ Fax_____

4 I am requesting health information be released for the following purpose(s):

☐ Coordination of Care ☐ Insurance Payment/Claim ☐ Legal ☐ Disability Determination

☐ Other (please specify): _____

5 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): _____

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

☐ Specific Dates _____

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6 Health information includes written and oral information

By indicating any of the categories in section 4, you are giving permission for written information to be released and/or received by ACP, and for a person/entity in section 3 to talk to ACP about your health information.

If you do not want to give your permission for a person in section 3 to talk to ACP about your health information, indicate that here (check mark or initials) _____. If checked, only written records will be shared.

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7 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: _____

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8 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: 14800 Galaxie Avenue, Suite 305, 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: 6160 Summit Drive N, Suite 450, 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