MINNESOTA MENTAL HEALTH CLINICS

RELEASE OF INFORMATION FORM – MUST BE PROVIDE SPECIFIC

Client:

Name:	Previous Last Name (if any)	
Address	Phone number	
City, State, Zip		
DOB		

Who has the information you would like released?

MUST BE PROVIDER SPECIFIC

Organization Name	Phone Number	Fax Number
Provider Name		
Address		
City	State	Zip

To Whom should the information be released to?

MUST BE PROVIDER SPECIFIC

Organization Name	Phone Number	Fax Number
Provider Name		
Address		
City	State	Zip

Information to be Disclosed:

Mental Health
- ☐ Intake/ Assessment
- ☐ Case Notes/ Progress Notes
- ☐ Psychiatric Evaluation
- ☐ Medication History
- ☐ Social History
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Psychological Reports/Testing Scores

Legal
- ☐ Court Documents/ Letters/Reports/Affidavits
- ☐ Information Investigations
- ☐ Child Abuse Investigations

School
- ☐ Academic Testing
- ☐ Other Academic Records

Chemical Dependency
- ☐ Chemical Dependency Treatment Records
- ☐ Evaluation Reports

Health
- ☐ History & Physical, Consultations, Discharge summaries
- ☐ Medication History

Other
- ☐ On going consultation and exchange of information
- ☐ Telephone Contact
- ☐ Letter/Affidavit
- ☐ Other (Specify) _____

Dates of Information to be disclosed :__ _____

Reason for Release:

☐ Continuation of Care ☐ Legal/Court ☐ On going consultation and exchange of information
☐ Personal ☐ Out of town move ☐ Telephone Contact
☐ Disability/SSI Appeal ☐ Other (Specify) ☐ At the request of the individual ☐ Short/Long Term Disability

Revocation:

I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires.
I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release will not condition treatment being provided. I have been informed of what information will be given, its purpose, and who will receive the information.

Authorization:

I authorize Eagan clinic, Edina clinic, Lakeville clinic, Minneapolis clinic, and Woodbury clinic to release the information marked above. I understand there may be a charge for my records per Minnesota Statute 144.335.

_____ _____
Signature of Client Date Signature of Parent/Guardian Date

_____
Personal Representative Date A Personal Representative is a person legally acting on behalf of an individual

Revised 12/3/2014