Release for Coordination of Care

Client:

Name:	Previous Last Name (if any)
Address	Phone number
City / State / Zip	
Date of Birth	Work/Cell number

Who has the information you would like released?

Name	Phone Number	Fax Number
Minnesota Mental Health Clinics (MMHC)	**651-454-0114**	**651-454-3492**
Address: **3450 O'Leary Lane**		
City: **Eagan**	State: **Minnesota**	Zip: **55123**

Coordination of Care

- ☐ I **AGREE** to allow MMHC to Release my treatment data to my Primary Care Physician. (continue filling out form)
- ☐ I **AGREE** to allow my Primary Care Physician to release my treatment data to MMHC. (continue filling out form)
- ☐ I **AGREE** to allow MMHC to release my treatment to Dakota County for services. (continue filling out form)
- ☐ I **DO NOT AGREE** to allow MMHC to Release information to my Primary Care Physician. (sign & date form)
- ☐ I **DO NOT** have a Primary Care Physician that I am currently seeing. (sign & date form)
- ☐ I **DO NOT AGREE** to allow MMHC to release my treatment to Dakota County. (sign & date form)

Primary Care Physician/ Information

Clinic Name		
Physician Name	Phone Number	Fax Number
Address		
City	State	Zip

Information to be Disclosed:

(x) Any information relating to Mental Health Status or Medication

Reason for Release:

(x) Continuation of Care **(x)** On going consultation and exchange of information **(x)** Telephone Contact

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 Minnesota Mental Health Clinics to release the information marked above.

_____ _____

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

Please return all information to: