AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ____, authorize Christian Heart Counseling to:

___disclose information to ___obtain information from

___exchange information with ___notify physician

TO:

_____________________________________ _______________________________________
(Name of Person) (Name of Agency)

____
(Address)

___________________________ _______________________________________
(City) (State) (Zip)

Fax # _______________________ Phone # _____________________________

Regarding: ______________________________ __________________________
(Client Name) (Date of Birth)
_____ myself _____ my daughter/son _____ other: ___________________

The information to be disclosed is:

_____ Discharge/treatment summary
_____ Admission/Intake Summary
_____ Progress notes
_____ Diagnostic Impressions
_____ Academic records/school functioning
_____ Chemical Dependency Evaluation
_____ Psychological testing
_____ Medical history & physical exam
_____ Social/Court Services Summary
_____ Medication history
_____ Other ____

Purpose of Release:

__Coordination of Care __Discharge and Continuation of Care __Client Request __Insurance __Litigation/legal purposes

__Other(Please specify ___________________________________

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. I understand that this consent will automatically expire without my express revocation upon fulfillment of the above stated purpose or one year from this date, whichever is sooner. I have the right to receive a copy or review information to be disclosed, if requested. Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.

____
Signature of patient or Authorized Person

____
Date

Send Records Here:

Christian Heart Counseling (**Check One**)
___1751 Tower Drive W STE 200 Stillwater 55082
___13911 Ridgedale Dr STE 460 Minnetonka 55305
___12940 Harriet Ave S STE 215 Burnsville 55337
___7362 University Ave NE STE 307 Fridley 55432
___1360 Energy Park Drive STE 330 St Paul, MN 55108
___7616 Currell Blvd, STE190 Woodbury, MN 55125

Fax: 888-675-8262 (all offices)