MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION
(Current clients may complete this form in the patient portal)

Client Full Name: _____ Other Names Used (if applicable): _____

Date of Birth: _____ **Phone Number:** _____

I Authorize: Minnesota Center for Psychology
2324 University Ave W, Suite 120
St. Paul, Minnesota 55114
Phone: (651) 644-4100
Fax: (651) 644-4885

To release information to and receive information from:

Name/Agency: _____ Phone:_____

Address: _____ Fax:_____

_____

Check **One**:
□ Primary Physician
□ Psychiatrist/Therapist
□ Emergency Contact
□ Other_____

Information which may be released includes (check all that apply):

□ **ALL**
□ Phone Contact
□ Diagnostic Assessments/Self Reports
□ Psychological Tests
□ Medication Information
□ Functional Assessments
□ Other _____
□ Discharge Summaries
□ Treatment Plans and Reviews
□ Crisis Plans
□ Clinical Notes/Records
□ Billing/Insurance Information
□ Emergency

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: **DO NOT release** records regarding: □Mental Health □Chemical Dependency □HIV/AIDS

This information may be released for the purposes of:

□ **Planning or continuing my care and treatment**
□ Determining eligibility for insurance benefits
□ Other (specify)_____
□ Determining eligibility for Social Security benefits
□ Billing
□ Emergency

Dates of information to be released: □ ALL □ Other _____

Your signature on this form indicates that you know what information will be given and what it will be used for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our *Notice of Privacy Practices.* You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal and/or state healthcare privacy protection.

Revocation Clause: I understand that I may revoke my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier.

_____ _____ _____
Client Signature **Date** SSN (voluntary)

_____ _____ _____
Parent/Guardian Signature (if applicable) Date Relationship to client

A photocopy of this release is as valid as the original