MINNESOTA CENTER FOR PSYCHOLOGY, LLC
AUTHORIZATION TO DISCLOSE INFORMATION

Client Full Name:	Other names used (if any):
Date of Birth:	Social Security Number (voluntary):
I Authorize: Minnesota Center for Psychology 2383 University Ave W, Suite 200 St. Paul MN 55114	Phone: (651)644-4100 Fax: (651)644-4885

To release information to and receive information from:

Name/Agency:

Agency Address:

Agency phone/fax:

Check One:

- ☐ Primary Physician
- ☐ Psychiatrist
- ☐ Emergency Contact
- ☐ Other_____

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

- ☐ **ALL**
- ☐ Psychological Tests/Diagnostic Assessments
- ☐ Functional Assessments
- ☐ Treatment/Crisis Plans and Reviews
- ☐ Other _____
- ☐ Phone Contacts
- ☐ Medication Information
- ☐ Discharge Summaries
- ☐ Contact Records

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

Dates of information to be released: ☐ **ALL** ☐ Other _____

This information may be released for the purposes of:

- ☐ **Planning or continuing my care and treatment**
- ☐ Planning or continuing CTSS
- ☐ Other (specify)_____
- ☐ Determining eligibility for insurance benefits
- ☐ Determining eligibility for Social Security benefits

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 healthcare privacy protections.

Revocation Clauses: 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.

Date of Expiration (not to exceed one year): _____

Client Signature:	Date:	Parent or guardian Signature (if applicable):	Date:
Phone Number:		Relationship to client:	
Signature of Witness:	Date:	Reason client is unable to sign:	

A photocopy of this release is as valid as the original