FamilyAttachment
COUNSELING CENTER
18322C Minnetonka Boulevard - Deephaven, MN 55391
Phone: (952) 475-2818 Fax: (952) 475-3356

Release of Confidential Information Authorization

Client's Name:________________________________ Birthdate: _________________________

I authorize and request the release of protected information from the clinical record as specified below.
Family Attachment and Counseling Center is authorized to: (MUST PLACE MARK IN ONE CIRCLE.)
O Exchange information with O Provide information to O Receive information from
The entity specified below. (please fill in)

Name ____
Street Address ____
City, State and Zip ____
Telephone ____
Fax ____

Please complete sections 1-3.

1. This authorization applies to the following types of information:
   □ All information in record **OR** □ Treatment plans □ Progress notes □ Testing data □ Reports
   □ Other (specify) ____
   Do **not** release information related to ____
2. I request this release of information due to (mark one):
   □ At request of individual for treatment/continuum of care.
   □ Other (specify) ____
3. OPTIONAL The authorization shall remain in effect a maximum of one year, or as specified below:
   Until date: ________________ (fill in) Until completion of activity:_____________________ (fill in)

I understand that I may revoke this authorization, in writing at any time, but that the revocation will not be effective to the extent that action has already been taken in reliance on the authorization. I understand that my therapist generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, if recipient is not a covered entity, and no longer protected by the HIPAA rule.

Signature: _____________________________________ Date: _____________________

If not client, specify relationship to client: ____

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