FamilyAttachment
COUNSELING CENTER

Authorization to Release Confidential Records and Information

A. Identifying information about me/the client

Name: _____ Date of Birth: ____/____/_____

Primary phone(s): _____ Social Security #:_____

_____

Name of parent/guardian (if applicable): _____ Phone: _____

B. I authorize the release of or exchange of information described below:

Person/organization: _____ Address: _____ _____ Phone:_____ Fax number: _____ Secure email: _____	Person or organization: FACC Address: 102 North Chestnut Street Chaska, MN 55318 Phone: 952 475 2818 Fax number: 952 475 3356 Secure email: _____

C. The records to be disclosed are marked by an X in the boxes below. The items *not* to be released/exchanged have a line ~~drawn~~ through them. All episodes of care are to be included unless page numbers and/or dates are indicated.

❑ Specific Date(s) of outpatient treatment to be released: _____ to_____

❑ Outpatient treatment records for psychological, psychiatric, or emotional illness as indicated below:

- ❑ Treatment Plans
- ❑ Reports
- ❑ Testing Data
- ❑ Billing or Attendance Records

❑ Other records (please describe)

_____

D. I authorize the transfer of these records for the following purpose(s) or uses:

- ❑ Further mental health evaluation, treatment, or care
- ❑ Coordination of care and treatment planning
- ❑ Qualification for services or benefits

❑ Other records (please describe)

_____

E. I authorize the Source named in section B above to share by telephone and/or face to face with the Recipient professional in section B any information that can assist with my/the patient's receiving treatment.

F. I understand the consequences if I refuse to allow this release. My consent is fully voluntary.

G. I understand that the Source of the information has no control of it after it has left the Source's premises.

H. I understand that I may revoke this ROI authorization, but that doing this will not recover the information that was released before the date of the revocation. I can do this at any time by writing to the Source named in section B. I understand that my therapist 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 ROI may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rule if the recipient is not a covered entity. If I do not void or cancel this ROI authorization, it will automatically expire one year from the date I signed it.

I. I have had the provisions of this form explained to me and believe that I fully understand this ROI.

J. Signatures:

_____ _____ ____/____/____

Client Printed name Date

_____ _____ ____/____/____

Parent/guardian/rep. if needed Printed name Date

Relationship: _____

❑ Copy for patient or parent/guardian ❑ Copy for Source of records ❑ Copy for Recipient of records Rev 6/2020