AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____
(Name of client **)** (Date of Birth)

I authorize _____ at **Northwest Counseling**
2351 Connecticut Ave Suite 105 Sartell MN 56377 to:
( ) obtain information from ( ) disclose information to ( ) exchange information with

Name::_____
Address:_____
_____

This information is needed for:
__ Treatment continuity __ Treatment consultation/coordination __ Client's request
__ Other:_____

Dates of service requested:
□ Present episode of care □ Past 7 years of medical records
□ Specific dates or years of treatment_____
Initial below the specific information to be disclosed:

( ) Social/Psychological/Psychiatric Assessment	( ) School Records
( ) Progress Notes	( ) Psychological Testing
( ) Diagnosis	( ) Summary of Treatment Contacts
( ) Dates of Treatment	( ) Discharge Summary
( ) Treatment Plan	( ) All Health Information

( ) Other (please specify):_____
Specifically, the following is requested: ( ) Chemical Dependency Treatment/Evaluation from a Chemical Dependency Program.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date___/___/___ Or specific event_____
I understand I may revoke this authorization in writing at any time by sending such written notification to the above office address. However, my revocation will be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that providers 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 this authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

A photocopy is valid as the original bearing my signature.

_____ _____
(Signature of client) (Date)

_____ _____
(or Legal/Personal representative) (By What Authority) (Date)