Rum River Counseling, Inc.
Individual, couple & family counseling
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# PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

**Instructions:**
Make sure **ALL** blanks on this form are **printed** and **complete** or we cannot process this request. **Please fill in complete address.**

Patient Name: _____ Patient Phone: _____
Patient Address: _____ City: _____ State: _____ Zip: _____
Patient Social Security Number: _____ Patient Date of Birth: _____

I, authorize _____ (Rum River Counseling, Inc. Provider) to:
____ Disclose Confidential Information to: ____ Obtain Confidential Information from: ____ Exchange Confidential Information with:
the following: Name: _____ Phone (required): _____
Address: _____ City: _____ State: _____ Zip: _____

**The purpose for which this information may be disclosed:**

____ Treatment ____ Patient Access ____ Insurance ____ Social Security Appeal
____ Care Coordination ____ Litigation ____ Other: _____

**What information may be disclosed:**

____ Diagnostic Assessment ____ Medication Information (current) ____ Appointment Information
____ Treatment Plan ____ Discharge Summary (most recent) ____ Verbal Consultation - Exchange
____ All Progress Notes ____ Only last 3 (three) Progress Notes ____ Psychological Testing Results (specify):
____ Other: _____ _____

_____ **I agree that my HIV status and/or drug/alcohol usage may be disclosed.**
**Initials**

**Dates Requested Information from:** _____ (mm/dd/yyyy) **to** _____ (mm/dd/yyyy)**.**

**This authorization expires (ends) on the following date, event or condition:** _____
(If a date, event or condition is not specified, this authorization expires twelve (12) months from the date I sign this form.)

**I understand that** I may revoke this authorization at any time by notifying, in writing, the facility listed above. Revoking this authorization does not apply to information that has already been released under this authorization. I have the right to inspect or copy the health information to be disclosed. Information that goes to a health care provider or health plan covered by federal privacy laws will be protected by federal privacy laws. Rum River Counseling, Inc. cannot re-disclose any information from other persons or entities as protected by state or federal privacy laws. I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as insurance companies. **A fee may be charged for retrieval and copying of records according to MN 144.335 and Federal Rule 164.521.**

Patient's Signature: _____ Date: _____/____/_____
Parent/guardian/personal representative (if applicable)
Signature: _____ Date: _____/____/_____
Witness (if client is unable to sign)
Signature: _____ Date: _____/____/_____

*If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health*