



Rum River Counseling, Inc.

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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 information.