RELEASE OF INFORMATION

515 Bridge St, Park Rapids MN 56470 218-366-9229 Fax: 218-237-2520
615 Anne Street NW, Suite A, Bemidji MN 56601 218-444-2233
11 Main St E, Menahga MN 56164

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I authorize Lake Country Associates 515 Bridge St Park Rapids MN 56470

☐ **to obtain my information from:** ☐ **to release my information to:**

_____

Agency / Facility / Individual's Name Address Phone # Fax#

Information to be released from: _____ to: _____

(Date of Birth) (One year from date of signature)

☐ Yes	☐ No	Psychological Assessment	☐ Yes	☐ No	Social History
☐ Yes	☐ No	Psychiatric Assessment	☐ Yes	☐ No	Education Information
☐ Yes	☐ No	Diagnostic Assessment	☐ Yes	☐ No	Discharge Summary
☐ Yes	☐ No	Chemical Dependency Assessment	☐ Yes	☐ No	Treatment Summary
☐ Yes	☐ No	Medical Report	☐ Yes	☐ No	Written/Verbal exchange
☐ Yes	☐ No	Progress Notes	☐ Yes	☐ No	Electronic Communication

- The above Information is released for the following purpose and that purpose only:

☐ **Treatment Planning** ☐ **Coordination of Services**

I understand that my protected information may include records regarding behavioral or mental health services, communicable diseases, HIV or AIDS, and/or treatment for alcohol and drug abuse.

Right to Revoke Release: I understand that I have a right to revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization, thus it is not retroactive.

Redisclosure: I understand that any information released in response to this authorization has the potential to be re-disclosed and the information may not be protected by Federal confidentiality rules. This information has been disclosed from records whose confidentiality is protected by Federal Law and the recipient of this information is prohibited from making any further disclosure of it without my signed consent.

Right To Treatment and Insurance/Payment Conditions: My treatment or payment for my treatment cannot be conditioned on the signing on this authorization. I further understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

I understand that my authorization of this disclosure is voluntary and I can refuse to sign it. I have the right to receive a copy of this Authorization after I sign it should I request. I further authorize that a photocopy or facsimile of this form will be acceptable as an original.

This Authorization will expire one year from the date of my signature or as otherwise specified by date, event or condition as follows: _____.

_____

Client Signature Date

_____

Parent or Legal Guardian Signature Relationship to Client Witness