



# RELEASE OF INFORMATION

515 Bridge St, Park Rapids MN 56470 Phone:218-366-9229 Fax: 218-237-2520  
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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)

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychological Assessment       | <input type="checkbox"/> Yes <input type="checkbox"/> No Social History           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Assessment         | <input type="checkbox"/> Yes <input type="checkbox"/> No Education Information    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diagnostic Assessment          | <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge Summary        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency Assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment Summary        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Medical Report                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Written/Verbal exchange  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Progress Notes                 | <input type="checkbox"/> Yes <input type="checkbox"/> 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