Release of Information Consent Form

Rose Psychotherapy

Client Information
Client full name:

Client date of birth:

I Authorize
Rose Psychotherapy
16204 Highway 7, Minnetonka, MN 55345
Phone: 612-293-8564; Fax: 612-568-9393
To:

Release information to

Obtain information from

Exchange information with

Organization/Individual Information
Organization Name:

And/or Person Name:

Address:

Phone:

E-mail:

Fax:

Information to be Released:

Medical history and evaluation(s)

Mental health evaluation(s)

Developmental and/or social history

Educational Records

Progress notes, treatment plans, or closing summaries

Other:

Purpose for Disclosure:

Treatment planning/care coordination

Determining eligibility for benefits or programming

Case review

Updating files

Court/legal action

Social service involvement

Other:

I understand:

- My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. Disclosure is allowed only with my authorization except in limited circumstances describes in Rose Psychotherapy's Privacy Notice.
- This authorization is voluntary and I can revoke this authorization at any time by providing written notice; except to the extent that action has been taken in reliance on it. I understand that such cancelation may be harmful to proceedings requiring records or, in some cases, may impact the quality of my care.
- I have the right to know what information is given and to whom before or after the signing of this document so that I am aware of all conversations being had regarding my treatment.
- I have the right to receive a copy of this authorization.
- A photocopy of this authorization will be treated in the same manner as the original.
- This authorization will expire in one year from the date I sign or unless I request an earlier request in writing.
- For disclosures other than for treatment, payment, and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))
- Communications resulting from this authorization will reveal that I receive services from Rose Psychotherapy.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA required Rose Psychotherapy to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- This authorization may be used by Rose Psychotherapy owned or managed programs upon transfer of my care to them.

Signature:
Client's signature:

Date:

OR authorized representative's signature:

Date:

Representative's name (printed):

Representative's relationship to client: