Information Release

Authorization for use and disclosure of protected health information. *Information may include medical, psychiatric, mental health, alcohol or substance abuse records. The individual has the right to restrict the disclosure of any of the types of information.*

Last name: ____________________________First name: ___________________________ MI ________ Birth date: ____________

Your signature on this form Authorizes release of information about the person named above as follows:

Village Wellness Center 1350 Energy Lane #109 St. Paul, MN 55108 O: 651-330-3653 F: 651-340-6107	☐ To release information to and/or ☐To receive information from	Organization: ___________________________________ Address: _______________________________________ City __________________ State _______ Zip code _____ Phone ______________________ Fax _________________

Your reason(s) for requesting information:

- ☐ Treatment/care planning
- ☐ Service coordination
- ☐ Review current care
- ☐ Payment for services
- ☐ Health insurance application
- ☐ Application or appeal for Social Security disability benefits
- ☐ Legal
- ☐ Other (specify) _________________________________

Information requested includes:

- ☐ Health care assessments/exams
- ☐ Diagnostic/functional assessment/psych evaluation
- ☐ Psychological/neuro psychological testing
- ☐ Immunization records
- ☐ Radiology or lab reports
- ☐ Images or videos
- ☐ Medications list
- ☐ Surgical/ER/physician's orders
- ☐ Treatment/care/support plan
- ☐ Progress notes/progress reviews
- ☐ Discharge summaries
- ☐ Identify dates I have received treatment
- ☐ Service or health care billing records
- ☐ Complete & send attached
- ☐ Release copy of my ENTIRE
- ☐ Release other information as indicated here:

____

Dates of records this release covers:_______________________ **OR** ☐ Release only most recent documents selected above.

Verbal communication: (check ONLY one)

☐ **Permission is granted for verbal communication** about my health/mental health care between parties identified above.
☐ **Exchange selected documents ONLY.** (no verbal communication)

INFORMATION REQUIRING SEPARATE RELEASE: A release requestiong any of the above records WILL NOT include the following records. **CHECK ONLY ONE** of the following & **NONE** of the above if you are requesting these records:

☐ Psychotherapy notes OR ☐ Chemical dependency assessment/treatment records OR ☐ HIV/AIDS testing results/info

By signing below, you acknowledge that:
*You are requesting the confidential information be exchanged between the agencies or persons listed.
*You may stop this consent at any time by writing to any organization, facility, &/or professional listed.
*You may inspect the records being released, or request a copy. You may be charged a fee for copies.
*You understand that once the information specified above is sent, it could be re-disclosed by the person that receives it &/or may no longer be protected by federal or state privacy laws.
*You understand that if the organizations listed are health care providers, they will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this consent form.
*If you choose not to sign this form to release information to an insurance company, your failure to sign will not impact your treatment; but that you may not be able to get new or different insurance; &/or may not be able to get insurance payment for your care.
*You understand that this consent will expire in one year from the date signed, or you may select to expire this consent on the following earlier date or event: (list date or event)

Client_____________________________ Legal Representative______________________________ Date _____/_____/_____
☐ Parent of minor **☐ Legal/court-appointed guardian/conservator (must include legal documentation if this circle is filled)**