PRIOMH HEALING AND SERVICES

PATIENT AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____

D.O.B: _____

HEALTH INFORMATION - I AUTHORIZE POINEER HEALING AND RESTORATION, LLC TO RECEIVE FROM:

RELEASE: - I AUTHORIZE PIONEER HEALING AND RESTORATION, LLC TO RELEASE INFORMATION TO:

(Please check one or both)

HEALTH INFORMATION RELEASE:

NAME: _____

ADDRESS: _____

_____C

ITY/STATE/ZIP CODE _____

PHONE NUMBER: _____

FAX: _____

INFORMATION TO BE RELEASED DATES ODF SERVICES _____

- All records: (please check to specify if not all records are being released)
  - Progress Notes
  - Intake
  - Treatment Plan
  - Medication
  - Test results/Evaluation
  - Discharge

PURPOSE OF RELASE: (please mark X to specify choice)

__ Continuation of Care
__ Personnel
__ Insurance
__ Legal
__ Disability

Other: _____

(ALL RECORDS PERTAINING TO MENTAL HEALTH/CHEMICAL DEPENDENCY/DRUG OR ALCOHOLABUSE OR HIV RELATED ILLNESSES AND TREATMENT RECORDS WILL BE RELEASED UNLESS INDICATED HERE DO NOT RELEASE RECORDS RELATED TO ANY OF THE PREVIOUSLY LISTED INFORMATION)

I understand this information will be disclosed to the above person, agency or organization from records whose confidentiality is protected by Federal Laws (42 CFR part 2) and by Minnesota statutes. I also understand that I may revoke this authorization at any time by giving written notice to the associated Clinic of Psychology, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire one year from the date of signing.

I understand that my clinician generally may not condition psychology/psychiatric services upon my signing an authorization unless the psychological /psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

SGNATURE OF PATIENT: _____

DATE: _____

SIGNATURE OF PARENT/GUARDIAN (if applicable): _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____ **EXPIRATION DATE:** _____