Minnesota Mental Health Clinics

RELEASE OF INFORMATION FORM

Client:	Name:	Previous Last Name (if any)	
	Address	Phone number	
	City State Zip		
	Date of Birth		
Who has the information you would like released?	Name	Phone Number	Fax Number
	Address		
	City	State	Zip
To Whom should the information be released to?	Name	Phone Number	Fax Number
	Address		
	City	State	Zip

Information to be Disclosed:

Mental Health
- ☐ Intake/ Assessment
- ☐ Case Notes/ Progress Notes
- ☐ Psychiatric Evaluation
- ☐ Medication History
- ☐ Social History
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Psychological Reports/Testing Scores

Legal
- ☐ Court Documents/ Letters/Reports/Affidavits
- ☐ Information Investigations
- ☐ Child Abuse Investigations

School
- ☐ Academic Testing
- ☐ Other Academic Records

Chemical Dependency
- ☐ Chemical Dependency Treatment Records
- ☐ Evaluation Reports

Health
- ☐ History & Physical, Consultations, Discharge summaries
- ☐ Medication History

Other
- ☐ On going consultation and exchange of information
- ☐ Telephone Contact
- ☐ Letter/Affidavit
- ☐ Other (Specify) _____

Dates of Information to be disclosed :_____

_____

Reason for Release:

☐ Continuation of Care	☐ Legal/Court	☐ On going consultation and exchange of information
☐ Personal	☐ Out of town move	☐ Telephone Contact
☐ Disability/SSI Appeal	☐ Other (Specify)	☐ At the request of the individual

Revocation:

I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires. I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release may result in not receiving services. I have been informed of what information will be given, its purpose, and who will receive the information.

Authorization:

I authorize Eagan Counseling Clinic, Maplewood Counseling Clinic, Minneapolis Counseling Clinic, and Woodbury Counseling Clinic to release the information marked above. I understand there may be a charge for my records per Minnesota Statute 144.335.

_____ _____

Signature of Client Date Signature of Parent/Guardian Date

_____

Personal Representative Date

A Personal Representative is a person legally acting on behalf of an individual

_____Minnesota Mental Health Clinics Eagan Clinic-3450 O'Leary Lane, Eagan MN 55123 Phone: 651-454-0114 Fax: 651-454-3492
_____Edina Clinic- 6525 Drew Ave. So. Edina, MN 55435 Appointments call 651-365-8222 Fax: 651-454-3492
_____Lakeville Clinic-18586 Joplin Ave., Lakeville, MN 55044 Phone: 952-435-8700 Fax: 952-435-0599
_____Maplewood-2785 White Bear Ave. Suite 403, Maplewood, MN 55109 Phone: 651-779-0069 Fax: 651-779-0206
_____Southwest Minneapolis Clinic-5346 Lyndale Ave. So., Minneapolis, MN 55419 Phone: 612-746-5888 Fax: 612-746-5518
_____Woodbury Clinic-1000 Radio Dr. Suite 210, Woodbury, MN 55125 Phone: 651-365-8209 Fax: 651-739-0272
Visit our Website at www.mnmentalhealth.com