

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ authorize *Mary M. Andersen APRN, CNS, MSN*

to: _____ (send) _____ (receive) _____ (exchange) the following information from/with

Name: _____

Address: _____

Phone: _____ fax: _____

Regarding ☐ myself _____ DOB _____

☐ minor _____ DOB _____

Information requested include:

- | | | |
|---|--|---|
| <input type="checkbox"/> Evaluations/Intake Summary | <input type="checkbox"/> Personality Profiles | <input type="checkbox"/> Academic/Educational Testing |
| <input type="checkbox"/> Behavior Programs | <input type="checkbox"/> Psychological Testing/Results | <input type="checkbox"/> Vocational Testing results |
| <input type="checkbox"/> Case/Progress Notes | <input type="checkbox"/> Summary Reports | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Chemical/Substance Use Reports | <input type="checkbox"/> Medical/Lab Reports | <input type="checkbox"/> Other Records (specify) |
| <input type="checkbox"/> Intelligence Testing Results | | |

For the following date(s) of treatment or condition: _____

The above information will be used for the following Purposes

- | | |
|--|--|
| <input type="checkbox"/> Planning Appropriate Treatment or Program | <input type="checkbox"/> Case Review |
| <input type="checkbox"/> Continuing Appropriate Treatment or Program | <input type="checkbox"/> Updating files |
| <input type="checkbox"/> Determining Eligibility for Benefits or Program | <input type="checkbox"/> Other (specify) _____ |

- * I understand that I may revoke this consent by written request at any time to the address listed at bottom of this form.
- * I understand that the revocation will not apply to information that has already been released in response to this consent.
- * I understand that once information is released pursuant to this authorization, Mary M. Andersen cannot prevent the re-disclosure of the information to another third party.
- * This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- * I understand that all records pertaining to psychiatric/mental health, chemical dependency and /or HIV/AIDS related illness will be released unless otherwise indicated by a check mark here _____. List restrictions here _____
- * I understand there may be a retrieval and copy charge associated with this release.
- * A copy that has not been altered will be considered as valid as an original.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness (if client is unable to sign) _____ Date _____

Signature of Person Informing _____ Date _____

Client of Rights

PLEASE SEND REQUESTED INFORMATION TO:

Advanced Practice Psych Services, Inc.

Mary M. Andersen, APRN, CNS, MSN

11800 Singletree Lane, Suite 312

Eden Prairie, MN, 55344

phone (952) 322-8532

fax (952) 322-8513