Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, & Glencoe

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____ authorize _____
(Client/Guardian) (Therapist)

to: ____ exchange/ ____obtain/ ____release protected health information to

_____
Name of Person and Agency

_____
Address/Phone

regarding: _____ myself
_____ my daughter/son, _____ DOB _____

I understand that the information to be disclosed is from _____ to _____ and includes:
Date Date

____Discharge / Treatment Summary
____Academic Records
____Psychological Testing
____Chemical Dependency Evaluation/Treatment
_____Medical History
_____Medication History
_____Physical Exam
_____Periodic Progress Reports
_____Other_____

These records are required for the purpose of: 1. _____ completing an evaluation for therapy,

2. _____ periodically reviewing treatment progress, or 3. _____Other: _____

I specifically request the release of the following information: ____Chemical dependency records or
____Psychotherapy notes.

--I understand that by signing this form, I am requesting that my protected health information be exchanged or obtained or released.
--I may stop this authorization at any time by written request to The Jonas Center Therapist or Director. If The Jonas Center has already released protected health information based on my authorization, my request to stop will not work for that protected health information.
--I understand that when protected health information is disclosed to a third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
--I understand that if the information is released to a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.
--If I choose not to sign this form and the organization is an insurance company, my not signing will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.
--This authorization will automatically end one year from the date this form is signed unless I indicate in writing an earlier date.

_____
Signature of Client and/or Parent/Guardian **Date**

_____
Witness

Revised 01/20/17