AUTHORIZATION FORM

This form, when completed and signed by you, authorizes your therapist to release/exchange protected information from your clinical record to/by the person(s) you designate.

I, _____ authorize**:**

_____

_____ **(Therapist)**
Relationship Therapy Center of MN
5407 Excelsior Blvd, Ste. B, St. Louis Park MN 55416
2600 Eagan Woods Dr., Ste. 200, Eagan, MN, 55121
Phone: 612-787-2832

and/or their administrative and/or clinical staff, to release/exchange the following information:

____ All Past & Ongoing Documentation and Consultation

OR:

____Initial Assessment/History
____Past and Ongoing Case Notes
____Summary of Treatment
____Medical/Lab Results
____Consultation Reports
____Other (specify) _____

____Treatment Plan(s)
____Psychological Testing and Evaluation
____Neurological Testing
____Chemical Dependency Evaluation
____Educational Assessments

(Provide specific and detailed description of the information that you want disclosed)

This information should only be released and/or exchanged with:

_____(Individual(s)/Clinic)

_____(Address)

_____ (Phone/Fax)

I am requesting my counselor to release/exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

_____

This authorization is considered ongoing, and does not expire unless I specify an expiration condition below:

____30 days after termination of treatment
____Upon my written request
____Immediately after requested information is received
____Other (Specify)_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my therapist's office address. I also understand that my revocation will not be effective to the extent that my therapist may have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client (Parent/Guardian for Minor) Date

_____ _____
Signature of Client (Parent/Guardian for Minor) Date

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.