Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____

I authorize Cambia Hills East Bethel to

☒ REQUEST information from:

☒ RELEASE information to:

Provider / Organization: Northeast Metro 916 Intermediate School District

Address: 2450 County Road F East, White Bear Lake, MN 55110

Fax #: 651-415-5510 Telephone: 651-415-5500

Provide Information via:

☒Written ☒ Fax ☒ Verbal ☒ Telephone ☒ Secure Email Email address: ahuebner@916schools.org

INFORMATION TO BE RELEASED (INDIVIDUALLY CHECK ALL THAT APPLY):

☒	Psychiatric Assessment	☒	Treatment Plans
☒	Discharge Summary	☒	Progress in Treatment
☒	Discharge Plans	☒	Medical Consults
☒	Psychological Consult/Testing	☒	Acknowledgement of Patient's Access of Service
☐	Alcohol/Drug Abuse Evaluation/Treatment **(Requires patient to consent)**	☒	History & Physical
☐	Lab Results **(CD / Pregnancy lab results require patient to consent)**	☐	Information re: HIV/AIDS status
☐	Reproductive Health Information **(Requires patient to consent)**	☒	Other: IEP

This information will be used for (check all that apply):

☒ Assessment, Treatment ☒ Coordination and Follow up ☒ Education ☐ Insurance Purposes

☐ Psychological Evaluation/testing ☐ Discharge Planning ☐ Legal

☐ Other (must specify) : _____ ☒ Acknowledge Patient's Access of Service/Referral

This Authorization remains in effect for one year from date signed, or: _____

(Specify date, event, or conditions that cause authorization to expire)

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Refer to Cambia Hills East Bethel's Notice of Privacy Practices for instructions regarding how to revoke authorizations or to inspect or receive copies of this information. A photocopy/fax of this authorization will be -treated in the same way as the original. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits or payment status. Once information is released, as authorized by this form, Cambia Hills East Bethel, its employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

NOTE: PATIENTS MUST PERSONALLY CONSENT FOR ALCOHOL/DRUG ABUSE AND REPRODUCTIVE HEALTH INFORMATION. PARENTAL CONSENT IS NOT VALID. PATIENTS 16 AND OLDER MUST PERSONALLY CONSENT FOR ALL MENTAL HEALTH RECORDS. PARENTAL CONSENT IS NOT VALID.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent / Guardian Date Name of staff that obtained and reviewed