Release of Information

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF CLIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Facility -- place where you are sending release.

_____

Street Address

_____

City, State and Zip Code

_____

Telephone/Fax/Email

RE: Client Name:_____DOB:_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ Direct consultation with provider (verbal and/or written).

☐ All medical records (including those pertaining to mental or behavioral health services), meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

The protected health information requested under this Authorization for Release of Client Information shall be released to Dr. Chara for the following purpose:

- ☐ Treatment planning for counseling
- ☐ Parenting Consultation

I understand the following:
See CFR § l64.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein and shall be as valid as the original. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol or drug abuse, and mental health. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records/information to:

Heart to Heart Child and Family Center for Counseling. LLC
127 County Road C, Suite 6
Little Canada, MN 55117

Signature of Client or Legally Authorized Representative (See 45CFR § l64.508(c)(l)(vi)

Date