

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the release of my health information

FROM: Name: (Person or Clinic) Address: City: State: Zip: Phone: Fax:

TO: Name: (Person or Clinic) Address: City: State: Zip: Phone: Fax:

I specifically authorize the release of the following information: (what illness or condition)

Reason for release of Information: (continuing care, completing a form, etc.)

- LETTER/FORM COMPLETION VERBAL COMMUNICATION PRINTED COPIES OF RECORDS ALL RECORDS PERTAINING TO PSYCHOTHERAPY/MENTAL HEALTH CLINIC AND CHEMICAL DEPENDENCY TREATMENT WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING

I specifically authorize the disclosure of printed copies of the following records:

Psychotherapy/Mental Health Clinic Chemical Dependency Treatment (Signature) (Date)

PATIENT IDENTIFYING INFORMATION

Name (Please Print) Maiden/former/alias: Student ID #: Boynton Medical Record #: Address: Telephone - Home: Work:

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of my signature. I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party. I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care. Your treatment will not be conditioned on your signing this authorization except for research-related treatment. You are entitled to a copy of this Authorization for the Release of Health Information.

Signature of Patient/Authorized Person (If authorized person signing, also print name.) Authorized Person's authority to sign (Parent, guardian, power of atty., etc.) Date

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other

PLEASE CHECK ONE: I or (valid picture ID required) will pick up the information at Boynton Information Desk on / / . (Allow at least one week unless other arrangements are made with Correspondence at: (612) 624-2121 or FAX (612) 624-4414.) Mail the information to the address at the top of the page. FAX the information to:

Charge/Fee:

OFFICE USE ONLY Completed by: Date sent to Info.Desk: Date Mailed: Received by: Completed Form filed in Medical Record by: