AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ *authorize Mary M. Andersen APRN, CNS, MSN*

to:_____(send) _____(receive) (exchange) the following information from / with

Name: _____

Address: _____

_____

Phone: _____ fax: _____

Regarding ( ) myself _____ DOB _____

( ) minor _____ DOB _____

Information requested include:

( ) Evaluations/Intake Summary
( ) Behavior Programs
( ) Case/Progress Notes
( ) Chemical/Substance Use Reports
( ) Intelligence Testing Results
( ) Personality Profiles
( ) Psychological Testing/Results
( ) Summary Reports
( ) Medical/Lab Reports
( ) Academic/Educational Testing
( ) Vocational Testing results
( ) Entire Record
( ) Other Records (specify)

For the following date(s) of treatment or condition: Mental Health | Chemical Dependency

The above information will be used for the following Purposes

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating files
( ) Other (specify) _____

* I understand that I may revoke this consent by written request at any time to the address listed at bottom of this form.
* I understand that the revocation will not apply to information that has already been released in response to this consent.
* I understand that once information is released pursuant to this authorization, Mary M. Andersen cannot prevent the re-disclosure of the information to another third party.
*This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
* I understand that I do not have to sign this authorization in order to obtain health benefits (treatment, payment or enrollment).
* I understand that all records pertaining to psychiatric/mental health, chemical dependency and /or HIV/AIDS related illness will be released unless otherwise indicated by a check mark here [ ] List restrictions here: _____
* I understand there may be a retrieval and copy charge associated with this release.
A copy that has not been altered will be considered as valid as an original.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness (if client is unable to sign) _____ Date _____

Signature of Person Informing _____ Date _____
Client of Rights

PLEASE SEND REQUESTED INFORMATION TO:

Advanced Practice Psych Services Inc.
Mary M. Andersen, RN, CNS, MSN
11800 Singletree Lane, Suite 204
Eden Prairie, MN. 55344

Phone (952) 322-8532
Fax (952) 322-8513