14130 23rd Avenue N. Plymouth, MN 55447
Phone: 763-383-7666 Fax: 763-383-6013

# AUTHORIZATION TO DISCLOSE HEALTH & DEVELOPMENTAL INFORMATION

Client's Name: _____ Date of Birth: _____

Caregivers Name (if applicable): _____ Relationship: _____

**I authorize Therapy Junction to receive from or disclose my health & developmental information to the following person or organization:**

Name: _____

Business Name (if applicable): _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

**AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:**
***PLEASE CHECK ALL THAT APPLY***

☐ Admission/Intake Information/Reports ☐ Diagnosis & Treatment Plan ☐ Progress/Case Notes
☐ Discharge Summary ☐ Evaluation Reports ☐ Progress Review/Reports
☐ Psychological Assessment Reports ☐ Medical/Physical History ☐ Medication Records
☐ Demographic Information ☐ Information Required for Case Coordination
☐ Verbal Communication (regarding):_____
☐ Educational Records (including IEP and IFSP) _____
☐ Billing Records / Statements (dates): _____
☐ Other (describe): _____
☐ Release entire record

**THE PURPOSE OF THIS AUTHORIZATION IS FOR:**
***PLEASE CHECK ALL THAT APPLY***

☐ Coordination of Care ☐ Third Party Authorization of Payment ☐ Communication Regarding Legal Issues
☐ Insurance Payment ☐ Determination of Eligibility for Services

**NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524**

I understand that if the person or entity receiving this information is not a health plan, health care or other provider covered by federal or state privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying Therapy Junction in writing and that if I choose to do so, my request to revoke will not affect any actions taken by Therapy Junction before receiving my revocation. I understand that unless otherwise revoked, this authorization will expire one year from the date it is signed. Therapy Junction will not refuse or revoke treatment if I refuse to sign this authorization. A photocopy or fax of this authorization will be treated in the same manner as an original.

_____ _____

Client/Legal Representative Date

_____

Describe legal representative's relationships

*Therapy Junction reserves the right to request documentation authorizing you to act as a legal representative.

**Tennessen Warning:**

You have the right to be told the intended use and purpose of the information requested, whether or not you can legally refuse to provide the information, what might happen if you provide or refuse to give the information, and who beside you, will be able to see the information you furnish.