Choices Psychotherapy

10201 Wayzata Boulevard, Ste 100, **Minnetonka**, MN 55305
7975 Stone Creek Drive, Ste 130, **Chanhassen**, MN 55317
7901 Xerxes Avenue South, Ste 225, **Bloomington**, MN 55431

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF INFORMATION WITH NOTARY SIGNATURE

1. Print this document on three separate pieces of paper.
2. Complete the second page, taking care to fill in each field.
    a. Complete client/patient information in the top sections of each page.
    b. Note the specific Choices provider the client/patient is seeing for therapy/psychiatry.
    c. Check the boxes in yellow indicating if you want two-way communication between your provider and the other entity or wish to limit communication to be either to or from your provider and the other entity.
    d. Note the name of the specific person/provider and their organization/clinic (with full address, phone, fax, email address, etc.) on the right side of the release with whom you wish to either have information sent to or obtained from.
    e. Check the boxes indicating whether you want verbal, written or both types of communication.
    f. Check the boxes noting what type of information you are authorizing for disclosure.
    g. Note the time range of the dates of service you are requesting.
    h. ***Do not sign the form until you are with a Notary of public as witness.***
3. Once the first page is completed, take the form (page 2-3 of this PDF) to a Certified Public Notary (often found at banks and in most businesses).
4. With the Notary, they will instruct you to sign the form, then will sign and place their official seal in the designated place on page 3.
5. Once the completed form is signed, **either mail or drop off the original form in-person to one of Choices Clinic offices** as noted at the top of all three pages of this form.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:		Date of Birth:
Address:	City, State, Zip:	Phone:

I authorize the disclosure of information: ☐ Between: ☐ To: ☐ From:

Name/Attention:			Name/Attention:		Relationship:
Organization: Choices Psychotherapy			Organization:		
Address: 10201 Wayzata Blvd, Ste 100			Address:		
City, State, Zip: Minnetonka, MN 55305			City, State, Zip:		
Phone: 952.544.6806	Fax: 952.545.0098	Email: admin@choicespsychotherapy.net	Phone:	Fax:	Email:

I authorize the disclosure of information: ☐ Written & verbal ☐ Written only ☐ Verbal only

The type of records that I authorize for disclosure are the following:

- ☐ Admission/intake information
- ☐ Psychological assessment/evaluation/testing
- ☐ Psychiatric assessment/evaluation
- ☐ School records, IEP, assessment/evaluation
- ☐ Chemical dependency assessment/evaluation
- ☐ Medical history/assessment/evaluation
- ☐ Family/social history
- ☐ Treatment plan
- ☐ Progress/case notes
- ☐ Progress reports/treatment plan reviews
- ☐ Termination/discharge/treatment summary
- ☐ Financial/health insurance information
- ☐ Court/legal records
- ☐ _____

DATE(S) OF SERVICE: _____

Use of information is to assist Choices Psychotherapy staff with clinical/coordination of services unless written below:

☐ Other: _____

- I understand my records are protected by data practices laws and cannot be released without my consent unless allowed by law.
- I understand that alcohol and drug treatment records may be further protected by federal regulations (see 42 CFR part 2).
- I understand that only the information and records indicated above will be released or obtained.
- I understand that the information will only be released to or obtained from the persons or entities indicated above.
- I understand that this consent does not authorize the recipient of the information or records to redisclose the information or records to anyone else unless authorized by law.
- I understand that the information will only be used for the purposes indicated above and shared only within Choices Psychotherapy.
- I understand that I may withdraw or modify this consent at any time, but that the revocation or modification will not affect any release or obtaining of information that occurred before the revocation or modification.
- I understand that Choices Psychotherapy will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign the consent form.
- I understand that this consent will expire and no longer be valid one year from the date I sign it.
- I understand my signature means that I have read this form or have had it read to me and explained in language that I can understand.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:		Date of Birth:
Address:	City, State, Zip:	Phone:

STOP! Please do not sign until in front of a notary.

_____ _____
Client Signature Parent/Guardian Signature

State of: _____
County of: _____

Signed before me this _____ day of _____ , _____ by

_____.
(Name of client/parent/guardian)

Seal/Stamp

_____
Signature of Notary Public

_____
Print Name