# MN Mental Health Consulting

7200 France Avenue South 117
Edina MN 55435
Phone: (612) 203-2961

# Authorization to Use/Disclose Health Information

For use under the HIPAA Privacy Rule and Minnesota Law

This authorization is required under the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule for uses and disclosures of protected health information not otherwise allowed by the Rule.

**I authorize:** ☐ **MN Mental Health Consulting/**_____

**and:** ☐ Other _____
**(Agency/Person who maintains information to be released)**

_____
**(Address)**

_____
**(City) (State) (Zip Code) (Phone) (Fax)**

**to exchange (both releasing and attaining) protected health information regarding:**

**Client Name:**_____ **Date of Birth:**_____

**I authorize the release of the following protected health information:**

**Medical:**
☐ Medication History/Summary
☐ Medical Reports

**Legal:**
☐ Child Maltreatment Reports
☐ Court or Probation Records
☐ Letters/Reports/Affidavits

**School:**
☐ Attendance Records
☐ Health Records
☐ Academic Records

**Mental Health:**
☐ Assessment/Diagnostic Findings
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Testing/Summary
☐ Treatment Plan/Goals
☐ Case/Progress Notes
☐ Discharge Summary

**Chemical Dependency:**
☐ History/Assessment Reports
☐ Treatment Records
☐ Evaluation Reports
☐ Discharge Reports

**Other:**
☐ Telephone Contact
☐ Assessment Coordination
☐ Case Coordination
☐ Specify: _____

**This information will be used and/or disclosed for the following specific purpose(s):**

☐ to enhance the services provided to me by MN Mental Health Consulting ☐ individuals involved in your care or payment for your care

☐ at your request to a third party specified by you ☐ other—provide description_____

I recognize that MN Mental Health Consulting cannot guarantee the privacy of information released by it under this authorization, but it is my intent that the party I authorize to receive it will consider it private.

I understand that information to be released by MN Mental Health Consulting includes information received from other organizations or health providers if such information has been integrated into and made part of the records. I acknowledge that release of the information constitutes waiver for the limited purpose designated herein of any therapist/client privilege or right to confidentiality that I may have under law. This consent will end one year from the date signed.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Client Signature | Personal Representative* or Legal Guardian (if minor) | Witness |
| _____ | _____ | _____ |
| Print Name | Print Name | Date |
| _____ | _____ | |
| Date | Date | |