SGW Psychological Services LLC
1585 Thomas Center Drive, Suite 105
Eagan, MN 55122
T: 651.493.9412
F: 651.365.1040

Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth _____ **Client ID:** _____

Full Address: _____

Maiden/Previous Names: _____

Email Address: _____ **Phone Number:** _____

Release Information From:

Name/Facility:

Address:

City/State/Zip

Phone & Fax:

Release Information To:

Name/Facility:

Address:

City/State/Zip

Phone & Fax:

Purpose of Release:

[ ] Continuing Mental Health Care [ ] Work Comp [ ] Disability Determination [ ] Personal

[ ] Insurance Claim [ ] Application for Insurance [ ] Legal [ ] Other: _____

Delivery Method: Date information desired by: _____

Release Format (Check only 1 option):

1. [ ] Paper via [ ] Mail **OR** [ ] Pick Up **OR** [ ] Fax (*as appropriate*) **Fax # :** _____

2. [ ] USB via [ ] Mail **OR** [ ] Pick Up *(must have permission of psychologist to use USB and must furnish USB device)*

3. [ ] Email to above email address *(must have permission of psychologist to use this option)*

Information to be Released:

Service Dates: From: _____ To: _____ **AND** all future records until authorization expires

[ ] History/Intake Info
Diagnostic Assessment
[ ] Psychological Evals
[ ] Billing Statements

[ ] Progress Notes
[ ] Discharge Summary
[ ] Alcohol/Drug Treatment Records

[ ] Treatment Plans/Goals
Goal Progress Records
[ ] Consultation Notes
[ ] Entire Medical Record

[ ] Other:

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:** _____

Signature: _____ **Date:** _____

Relationship of Person Signing (If not patient): _____