Marie Ridgeway & Associates * 1030 County Road E #140 Shoreview, MN 55126 * 612-314-9169

CONSENT FOR THE RELEASE OF INFORMATION

Client Name:_____ Birth Date: ____/____/____
Address:_____
City:_____ State:_____ Zip Code:_____
Telephone #:_____ Cell#_____
I am requesting that my health information be:

____Exchanged with ____Released to ____Obtained From

Name:_____ Relationship to client:_____

Facility Name:_____

Mailing Address:_____

Phone:_____ Fax:_____

Reason for releasing my health information_____

Please check information to be released and indicate the dates of services to be included:_____

_____Discharge Summary
_____Evaluations/Assessments including Diagnostic, Psychiatric, Psychological, Medical, Chemical Dependency, Emergency
_____Psychotherapy Notes
_____Treatment Plan/Rehabilitation Plan/Community Support Plan
_____Laboratory Reports
_____Courts/Corrections Information
_____School or Educational Informational
_____Social Services Agency Information
_____Other (specify**)**:_____

I Understand:
I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information, and known consequences of this release. The information to be released is private and any subsequent use and release is controlled under the Minnesota Data Practices Act (Minn. Stat.1982 Chapter 13).
I understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. Further, I realize that Marie Ridgeway LICSW, LLC cannot prevent the disclosure of records released as a result of this request and the records may not be subject to privacy rule protections: therefore Marie Ridgeway LICSW, LLC is released for any and all liability resulting from disclosure's. I have the right to revoke this authorization at any time by giving written notice to Marie Ridgeway LICSW, LLC. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire within 1 year after the date of my signature. I understand that the revocation will not apply: 1) To information that has already been released in response to this authorization; or 2) to my insurance company as the law provides insurer with the right to contest a claim under my policy.
I need not sign this authorization to receive the services that are court-ordered or being created solely for a third party (i.e. consultation).
This authorization will permit two-way telephone communication and exchange of information by electronic methods that may include unsecured email. I am entitled to a copy of this authorization once I have signed it, and I may review/request copies of information disclosed. A photograph or facsimile of this authorization is as effective as the original. I have been informed of my right to refuse to release this information.

Consent expires after 1 year unless a sooner date is listed here:_____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Client