RIVER CITY CLINIC, P.A.
1360 Energy Park Drive, Suite 340
St. Paul, MN 55108
Phone: (651) 646-8985 Fax: (651) 646-3959

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Print client's legal name _____
Previous names _____Date of Birth: ____/____/____
Phone numbers (Home) _____ (Work) _____ (Other) _____

1. **Please release my records from:** *(Who has your records?)*
   Person, clinic or organization: _____
   Address: _____ City: _____
   State: _____ Zip code: _____ Phone: _____ Fax: _____

2. **Please release my records to:** *(Who needs your records?)*
   Person, clinic or organization: _____
   Address: _____ City: _____
   State: _____ Zip code: _____ Phone: _____ Fax: _____

3. **These are the records I would like to release:** *(Please check all that apply)*
   _____ All health information
   OR to only release portions of your health information, indicate the categories to be released:
   _____ Brief summary of my record _____ Discharge summary
   _____ Medical records _____ Diagnosis
   _____ Psychological test results _____ Social or family history
   _____ Progress notes _____ Other
   The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:
   _____ Psychotherapy notes *(this consent cannot be combined with any other)*
   _____ Alcohol and drug use information
   For dates of treatment: _____
   Date records are needed by: _____ *Will records be picked up?* ____Yes ____No
   This information will be released via: _____Phone _____Fax _____Mail

4. **Purpose:** _____Coordination of treatment planning _____Evaluation _____Other

5. **I understand the following:**
   - If I change my mind, I may write to the address in section 1 to stop the release of my records. This will not apply to records that have already been released.
   - This form expires one year after I sign it, or on (expiration date: _____).
   - There may be a fee for releasing these records.
   - Once the records are released to the person, clinic or organization named above, the clinic releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
   - If I do not sign this form, I will still be treated.

_____ _____ _____
Date *Signature of patient or authorized person* *Authorized person's authority to sign (proof required)*

Reason patient is unable to sign: _____Minor _____Deceased _____Other:_____

ORIGINAL to Chart *PHOTOCOPY as needed for Patient*