Release of Information

Client's Name: _____DOB:_____

Relationship to Client: Self Parent/Legal Guardian Other

I authorize Manes For Change LLC, located at 1884 Mahogany Street in Mora, MN
to: Send Receive Both Send and Receive

The following information:

- Treatment Plans
- Diagnostic Assessment & Recommendations
- Discharge Summary
- Progress in Treatment/Progress Notes
- Chemical Health Assessment & Recommendation
- Collateral Information For Assessments
- Other

With:

_____

Name/Business

_____

Address

_____

Phone Number Fax Number

The above information will be used for the following purposes:

- Treatment Planning
- Continuing Appropriate Treatment or Program
- Determining Eligibility for Benefits or Program
- Case Review
- Updating Files
- Collaborative Care
- Other

The purpose or intent of the information shared is:

- Coordination or Collaboration of Care

Assessment/Treatment Planning
Discharge Planning
Insurance/Billing
Acknowledgement of Client's Services
Discussing Progress in Treatment

I am authorizing the information to be shared in the following ways:
Verbally
Written
Mailed

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1 Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____Date: _____

Printed Name: _____