Minnesota CarePartner
393 North Dunlap Street #736
Saint Paul, MN 55104
P: 612-289-5656 F: 651-925-0278

Release of Information

Patient Information

First Name_______________________________________ M.I_____ Last Name_____________________________________

Maiden or Other Known Name ____ Date of Birth__________________

Home Address____

Daytime Phone ________________________________ Parent/Guardian____

I give Permission for the following entities to exchange information:

Minnesota CarePartner 393 North Dunlap Street # 736 Saint Paul, MN 55104 P: 612-289-5656 F: 651-925-0278	AND	Name_____________________________________ Address___________________________________ ____ Phone________________Fax_________________ Relationship to client_________________________

Information to be Released

Important: Indicate only the information that you are authorizing to be released.

___Specific Dates/years of treatment______________________

___All Health information

OR to only release specific portions of your health information, indicate categories to be released:

___History/Physical	___Evaluations	___Billing Records
___Diagnostic Assessment	___Progress Notes	___Insurance Information
___Discharge Summary	___Functional Assessment	___Other______________________

Health information includes written and oral information. By indicating any of the categories above, you are giving permission for written information to be released and for the above ensures to speak to each other about your health information.

___If you **DO NOT** want to give your permission for verbal communication please initial here

Reason(s) for releasing information (Please choose one or more)

___Review client's current care	___Payment	___Other______________________
___Client's request	___Legal	
___Treatment/continued care	___Social Security Administration	

I understand that by signing this form, I am requesting that the health information specified on this form be exchanged with the third party named on this form. I may stop this consent at any me by writing to the organization(s), facility(ies) and/or professional(s) named above. If the organization, facility or professional named above has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified above is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named above is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This Consent will end one year from the date the form was signed unless I indicate an earlier date or event here:
Date ___________________Or specific Event____

Client Signature____ Date ___________________

Authorized Representative's signature ____ Date ___________________

Printed Name____________________________________ Relationship to Client______________________________________

Witness Signature____ Date ___________________