PRIMROSE MENTAL HEALTH PLLC
1400 Madison Ave Ste 602, Mankato MN 56001
Fax: 360-282-1236 info@primrosementalhealth.com Tel. 507-613-3883

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Client Information	Patient Name: _____ Date of birth: _____ Address: _____ Phone: _____
I authorize this clinic to: ☐ Send ☐ Receive ☐ Exchange	Primrose Mental Health 1400 Madison Ave Ste 602, Mankato, MN 56001 P: 507-613-3883 Fax: 360-282-1236 Psychiatric Provider: Paul Matson ***For MEDICAL RECORDS please fax it to 360-282-1236***
I authorize this clinic/ organization/person to: ☐ Send ☐ Receive ☐ Exchange	Clinic/Organization/Person: _____ Address: _____ Phone: _____ Fax: _____ Email: _____
Information to be released via: ☐ Fax ☐ Mail ☐ Email	Please check information to be released and indicate the dates of service to be included: _____ ☐ Evaluations/Assessments including Diagnostic, Psychiatric, Psychological, Medical, Chemical Dependency ☐ Psychotherapy Notes ☐ Psychological Testing/Neuropsychological Testing Results ☐ Chemical Dependency Treatment Summary/Discharge Summary ☐ Facility Admission Summary/Discharge Summary/History and Physical ☐ Primary Care Office Visit Notes ☐ Laboratory and EKG Reports ☐ Current Medication List (and historical medication trials when available) ☐ Other: _____
Purpose for release of information:	☐ Transfer of care Relationship: _____
	This consent expires one year from the date of signature unless otherwise revoked.

I have been instructed as to the information to be released, the purpose and intended use of the released information, who will receive the information, and any known consequences of this release. The information to be released is private and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn. Stat. 1982 Chap. 13). I understand that the information to be obtained may include Chemical Dependency Information and/or medical information regarding topics including but not limited to HIV or AIDS.

I understand that State and Federal privacy laws protect my records. My records can be released only if I give 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 *Primrose Mental Health PLLC* cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections, therefore *Primrose Mental Health PLLC* is released from any and all liability resulting from re-disclosure.

I have the right to revoke this authorization at any time by giving written notice to *Primrose Mental Health PLLC*, I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire one year after the date of my signature. I understand that the revocation will not apply to information that has already been released in response to this authorization, nor will it apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

This authorization WILL permit two-way communication via face-to-face, telephone, and electronic methods of information exchange.

I am entitled to a copy of this authorization once I have signed it. 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.

Client or Authorized Signature: _____ Date: _____

Authorized representative may be required to show a legal document supporting his/her authority to act on a patient's behalf.