MN THERAPIES

3166 N. Lincoln Ave. Suite 217 - Chicago, IL 60657

Phone -773.270.2246

E-mail - mnovaklcsw@gmail.com

www.mntherapies.com

Authorization For Release and Exchange of Information

Records to be released from/to:

MN Therapies
3166 N Lincoln Ave. Suite 217
Chicago, IL 60657
773.270.2246
mnovaklcsw@gmail.com

Please mail authorization form to the address above.

Patient's Name ____

Address ______________________________ City/State/Zip ______________________________

Date of Birth ____ / ____ / _______ Social Security Number _**X**_-_**X**_-______ Phone ( ) ______________________

I ______________________________hereby authorize MN Therapies to release (written/oral/electronic) information to and exchange information with:

Agency/Facility/Person: ____

Address:______________________________ City/State/Zip: ______________________________

Phone ( ) ______________________________ EMAIL ______________________________

INFORMATION TO BE RELEASED/EXCHANGED

____ Discharge Summary ____ Clinic/Office Records ____ Psychological Testing/Assessment

____ Treatment Planning ____ Consultations ____ Integrated Assessment

____ Record Abstract (All progress notes, Integrated Assessment, Consultations, Psychological Testing, Treatment Plans and Reviews, and Other Diagnostic Tests

____ Patient review of record

____ Other (please specify) ____
____
____

Concerning the care of the above patient from dates ______________________ to ______________________

This abstract WILL include sensitive information such as mental, substance abuse, or HIV/AIDS unless checked below.
(Check all that apply)

____ Mental Health ____ Substance Abuse ____ HIV/AIDS ____ Other ___________________________

These records are released/exchanged for the purpose of (Check all that apply)

____ Continuity of Care ____ Attorney/Client relationship ____ Insurance ____ At the request of the patient

Allow (5-10) Business Days for Processing

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended.

____

Signature: Patient or Legally Authorized Patient Representative Date of Signature

____

Relationship to Patient

____

Signature of Witness Date of Signature

The Standards for Privacy of Individual Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of information is expressly permitted by written consent of the person to whom it pertains by 42 CFR Part 2.

A general authorization for release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997. Nov.2, 1987]