Authorization to Release Protected Health Information

CLIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____-____- ____ SS#:_____-_____- _____ CTSS RECORD #: _____

MO DAY YR

ADDRESS:_____CITY:_____STATE:____ZIP: _____

DAY PHONE:_____EVENING PHONE: _____

I hereby authorized Rise Autism LLC **information** _____ ***(Print Name of Provider)*** **to release from my record as indicated below to:**

NAME: Rise Autism LLC (Staff Name)

ADDRESS:1913 Broadway St NE #100, Minneapolis, MN 55413, USA

INFORMATION TO BE RELEASED:

- ❑ History and physical exam
- ❑ Intake & Assessment*(incl. psych/med. History)*
- ❑ Presence in Treatment *(admission/discharge dates)*
- ❑ Diagnosis
- ❑ Progress notes
- ❑ Education/School Records
- ❑ Discharge Summary
- ❑ Coordination of Care Health Form
- ❑ Education/School Records
- ❑ Treatment/Service Plan

❑ Other: (specify)_____

COMMENTS:

PURPOSE OF DISCLOSURE: ❑ Treatment/Service Planning ❑ Consultation/second opinion ❑ Continuation of care
❑ Legal ❑ School ❑ Insurance ❑ Ongoing Treatment
❑ Other (please specify): _____

I understand the following:

- ✓ I understand that I may cancel this authorization at any time. To cancel this authorization, I must notify Brighter Possibilities in writing. This authorization will be canceled once Rise Autism LLC has received my written notice. The exception to this would be if my information has already been released prior to my signing this authorization. In that case, this information would not have been protected by Federal privacy regulations.
- ✓ The information released in response to this authorization may be re-disclosed to other parties.
- ✓ My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be enforced and effect until one year from date of execution at which time this authorization expires

_____ _____ OR _____ _____
SIGNATURE OF CLIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

WITNESS BY (Rise Autism STAFF) DATE RELATIONSHIP TO CLIENT