AUTHORIZATION FOR RELEASE OF PRIVATE INFORMATION

A copy of this is considered as valid as the original

Client Name:______________________________________

Client Address:_____________________________________

Date of Birth: ___________________

I hereby authorize ______________________ HPCA Psychotherapist

Highland Park Counseling Associates LLC
790 Cleveland Ave. S. # 207
St. Paul, MN 55116
Phone: 651-690-0953 Fax: 651-690-0968

To contact:____

Phone Number:________________________________

Fax Number:__________________________________

with the information that I am (or will) be receiving services. In addition, I authorize and the named party to exchange information as necessary to facilitate my treatment.
The information to be released are items indicated:

- ☐ My diagnosis
- ☐ The services I receive
- ☐ The person (s) providing the service,
- ☐ The dates of service,
- ☐ Treatment recommendations,
- ☐ Crisis Intervention
- ☐ Case Management
- ☐ Phone Consultation
- ☐ Other __________________________

I understand that this consent will expire within one year from now unless I revoke it earlier. I understand that I may revoke this consent at anytime, but that the revocation will not have any effect on the information released prior to notification of revocation. I realize that Highland Park Counseling Associates LLC 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 Highland Park Counseling Associates LLC is released from any and all liability resulting from re-disclosure.

_______________________________________ **Date:**__________
Client Signature

_______________________________________ **Date:**__________
Guardian Signature if a minor

_______________________________________ **Date:** __________
Witness