AUTHORIZATION FOR RELEASE OF PRIVATE INFORMATION TO PRIMARY CARE PHYSICIAN

A copy of this will be considered as valid as the origin

____ _______________________

Client Name **Birth Date**

____

Address

I authorize the release of information regarding services provided to me during the period of__one year __other period

Information to be released is case management, interaction of medical, behavioral, and psychological factors, and needs for crisis intervention.

Primary Care Physician's Name__________________________________

Clinic Name:____

Address:____

Phone:_______________________**Fax:**__________________________

HPCA Therapist:____________________________________

Highland Park Counseling Associates 790 Cleveland Ave. S. #207

St. Paul, MN 55116

651-690-0953 Fax: 651-690-0968

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.

AUTHORIZATIONS SIGNATURE AND INTIAL BLOCK

CONTENT OF AUTHORIZATION PAGE	**INITIALS**	**DATE**
NOTICE OF HEALTH INFORMATION PRACTICES		
ACKNOWLEGEMENT OF RECEIPT OF THE NOTICE OF ELECTRONIC MEDIA POLICIES		
OFFICE POLICIES AND FEE AGREEMENT		
INFORMED CONSENT TO TREATMENT FOR ADULT OR MINOR		
UNDERSTANDING OF MEDICARE PRACTICES AND FEDERAL POLICY		
AUTHORIZATION OF INFORMATION RELEASE TO PRIMARY CARE PHYSICIAN		

My signature below indicates that I have read and understood the contents of the HPCALLC Intake Notebook, the individual policies of which I initialed above.

____ ____________

Signature of Client ***Date***

____ ____________

Parent if client is a minor ***Date***

____ ____________

Witness ***Date***