Authorization for Release of Private Information
Highland Park Counseling Associates; LLC

Client Name: _____
DOB: _____
Client Address: _____
Client phone number: _____

I hereby authorize: _____
Provider at Highland Park Counseling Associates LLC 790 Cleveland Ave. South # 207
St. Paul, MN 55116 Phone: (651)690-0953 Fax: (651) 690-0968

Please Check One:
____ To disclose (Provider can only give) information
____ To obtain (Provider can only receive) information
____ To exchange (Provider can give and receive) information

With: (Name of individual)
Organization or relationship to client: _____
Phone #: _____ Fax #: _____
Email address: _____
Mailing address: _____

Regarding the following information:

_____

Via: (Please check one or both)
____ Phone
____Email

I authorize this release of information regarding services provided to me during the period of__one year __other period: _____. Information to be released is to be used for case management, coordination of care between medical, behavioral and psychological providers, continuum of care or crisis intervention.

I understand that I may revoke this consent at any time. The revocation will not have any effect on the information released prior to notification of revocation.

Signature of client: _____
Date:_____