MHS
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Edina, MN 55435
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CONSENT FOR RELEASE OF PRIVATE INFORMATION

CLIENT NAME:	DOB:	SS#:

Team Member Type	Full Name	Company	Phone Number	Fax Number

INFORMATION TO BE RELEASED INCLUDES THE FOLLOWING ITEMS. PLEASE CHECK EACH BOX APPLICABLE AND INCLUDE SPECIFIC ITEMS OR TEST RESULTS REQUESTED AND ESTIMATED DATES OF THOSE ITEMS REQUESTED

- ☐ Verbal information related to treatment
- ☐ A copy of my entire record
- ☐ Mental health discharge summary/after care planning
- ☐ Chemical health assessment and treatment records
- ☐ Psychological testing
- ☐ Diagnostic Assessment
- ☐ Treatment Plan/Quarterly Reports:
- ☐ Other:_____

THIS INFORMATION WILL BE RELEASED FOR THE FOLLOWING PURPOSES:

- ☐ Coordination with treatment team
- ☐ Determining eligibility for insurance benefits
- ☐ Planning and/or continuing my care and treatment
- ☐ Other: (Specify) _____

The information to be released is private and cannot be released without my consent unless the law provides for the release of the information.

This release allows the mutual exchange of specified information between Mental Health Systems, PC and the party named above.

I have been told why I am asked to consent to the release of the above information and how the information will be used. I understand that I am not required by law to consent to the release of the information but if I do not consent, it may interfere with or prevent achievement of my treatment goals.

REVOCATION CLAUSE: I understand that I may revoke this consent upon written notice.

Please Initial:

_____**I agree to this Consent for Release of Private Information to remain in full effect until two months after my discharge from treatment at Mental Health Systems, PC.**

_____ _____ _____ _____

Signature of person consenting to release of information | Date | Legally required parent or guardian | Date

_____

Signature of person informing you of your rights