Adult, Child and Family Services, LLC

103 N. Broad St. Mankato, MN 56001 Phone: (507) 387-3777 Fax: (507) 344-1726

AUTHORIZATION FORM

This form when completed and signed by you, authorizes Adult, Child and Family Services, LLC to release and/or receive protected information from your clinical record to or from the person you designate.

Client Name:_____ DOB:_____

I authorize _____ and/or his or her administrative and clinical staff to ¨ release ¨ receive:

_____ Psychological Test Results

_____ Psychological Assessment

_____ Other:_____

_____ Progress Summary

_____ Family & Social History

_____ Treatment Plans

Patient /Personal Representative/Legal Guardian must initial items checked

This information should only be released to/received from:

_____

_____

I am requesting my clinician release/receive this information for the following reason(s):

_____

This authorization shall remain in effect until:

One year from date of signature or upon circumstances listed below:

_____

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Adult, Child and Family Services, LLC. However, your revocation will not be effective to the extent that Adult, Child and Family Services, LLC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient/Personal Representative/Legal Guardian Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided: _____