ellie FAMILY SERVICES
www.elliefamilyservices.com
phone: 651.313.8080 fax: 651.925.0610

Med Management Release of Information Consent Form

I, _____, D.O.B. _____, am requesting health information, in written and/or oral format, be

☒ Exchanged with

the following individual(s) or entity(ies): _____

Fax Number: _____ Phone: _____

I am requesting health information be sent to:

Ellie Family Services
Attn: Medication Management Team
1150 Montreal Ave # 107
St Paul, MN 55116
Phone: 651.313.8080
Fax: 651.925.0610

Information to be released:

☐ Specific dates/years of treatment: _____

☐ All health information (excludes information from a chemical dependency program and psychotherapy notes)

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ Discharge/Treatment Info
☐ Laboratory report	☐ Emergency Room/Hospital Records	☐ School/Criminal Records
☐ Medications	☐ Progress Notes	☐ Social History
☐ EKG	☐ Substance Treatment	

☐ Other (specify): _____

I understand that all information about me is private. It cannot be shared with anyone without my permission unless the law says it can. I understand that I may refuse to give my permission to share this information. If I refuse, I may not receive the services I am requesting.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY EXPRESS WRITTEN NOTIVE TO ELLIE FAMILY SERVICES, PLLP., EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT OR INFORMATION HAS BEEN RECEIVED AS A RESULT OF IT.

This form will expire one year from the date signed unless I indicate an earlier date or event here:

Date: _____ Or specific event: _____

I understand that this information will be given only to people who need it to do their jobs. The information will be used only for the reason stated above.

Client Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____