Release of Information Consent Form

1. **PATIENT INFORMATION**

Patient Full Name: ______________________________

Patient Date of Birth: ______________________________

2. **I AUTHORIZE**

Ellie Mental Health
1370 Mendota Hts Rd
Mendota Hts, MN 55120
Phone: 651-313-8080 Fax: 651-925-0610

To: ☐ release information to ☐ obtain information from ☐ exchange information with the person/organization in section 3.

3. **ORGANIZATION/INDIVIDUAL INFORMATION**

Organization Name: ______________________________

And/or Person Name: ______________________________

Address: ______________________________

City: ____________________ State: __________. Zip: __________

Phone: ____________________ Fax: ____________________

4. **INFORMATION TO BE RELEASED**

☐ Specific dates/years of treatment: ______________________________

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

OR indicate the specific categories to be released:

☐ Diagnosis ☐ Psychological Evaluations ☐ Discharge Summary

☐ Treatment Plans ☐ Social History ☐ Provider/Hospital Records

☐ School/Criminal Records ☐ Other: ______________________________

5. **PURPOSE FOR DISCLOSURE:**

☐ Coordination of Care ☐ Legal/Court Order

☐ Personal Request ☐ Emergency Contact

☐ Other: ___________________________________

6. **I UNDERSTAND THAT:**

- My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Ellie Mental Health's Privacy Notice.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Ellie Mental Health's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III))
- Communications resulting from this authorization will reveal that I receive services at Ellie Mental Health.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires Ellie Mental Health to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- This authorization may be used by Ellie Mental Health owned or managed programs upon transfer of my care to them.

7. **SIGNATURE**

Patient's Signature: ____ Date: _____________

OR Authorized Representative's Signature: __________________________ Date: _____________

Representative's Name (printed): ____

Representative's Relationship to Patient: ____