Release of Information Consent Form

1. PATIENT INFORMATION

Full Name: _____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
Email: info@elliementalhealth.com

To: ☐ release information to ☐ obtain information from ☐ exchange information with

3. INITIAL ACTION

☐ **KEEP ON FILE** ***(For Future Use or verbal communication between providers. Records will <u>not</u> be sent immediately)***

☐ **SEND/REQUEST RECORDS** ***(Records will be sent immediately)***

4. ORGANIZATION/INDIVIDUAL INFORMATION

Organization Name:_____
And/or Person Name:_____
Address: _____
City: _____ State: _____. Zip: _____
Phone: _____ Fax: _____

5. INFORMATION TO BE RELEASED

Only release specified records below:

☐ Most Recent Health Information (Diagnostic Assessment, 3 most recent progress notes, and treatment plan) ☐ Most Recent Psychological Evaluation

☐ Most Recent Diagnostic Assessment ☐ Most Recent Treatment Plan

☐ Diagnosis ☐ Social History ☐ Discharge Summary

☐ Other: _____

OR choose the specified category:

☐ School/Criminal Records ☐ Provider/Hospital Records

OR

☐ Specific dates/years of treatment: _____

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

6. PURPOSE FOR DISCLOSURE:

☐ Coordination of Care ☐ Legal/Court Order ☐ Personal Request

☐ Emergency Contact ☐ Other: _____

7. METHOD OF COMMUNICATION:

☐ Phone ☐ Fax ☐ Secure Email_____

☐ Mail ☐ Other_____

8. 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.

9. SIGNATURE

Patient's Signature: _____Date: _____

OR Authorized Representative's Signature: _____Date: _____

Representative's Name (printed): _____

Representative's Relationship to Patient: _____