Healing connections Therapy Center

PHONE: 952-892-7690
FAX: 952-898-4930
1751 Southcross Drive West
Burnsville, Minnesota 55306

Primary Care Physician Consent for the Release of Information

This authorizes Healing Connections Therapy Center and its providers to use and disclose the specific health information described below concerning:

Client:_____Date of Birth:_____

This will authorize Healing Connections Therapy Center and its providers to release to/obtain from

Name/Company _____

Address _____

_____

Phone # _____ Fax # _____

Information from the medical record maintained from (dates):_____

The information to be disclosed is: (please initial)

	History and intake information		Social/ Psychological/ Medical reports		Other (specify)
	Consultation notes/ progress reports		Court or probation records		Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)
	Treatment plan, goals, and results		Medications used in treatment		

The purpose of the information release is: (please initial)

	Diagnosis and evaluation		To facilitate treatment		Treatment planning		Other

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) I cannot deny my services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Signature of Client Date

_____ _____
Signature of parent or guardian or witness Date

_____ _____
Healing Connections Provider Date

I **REFUSE** to have information sent to my primary care physician:			
Signature:		Date	