AMPERS&ND
Psychological Services

Release of Information

Client Information

Client's Name: ____
Legal Guardian (if applicable): ____
Date of Birth:____
Address: ____
Phone Number: ____

I authorize:

Ampersand Psychological Services
28 Union Street North, Mora, MN
p| 320-703-8151 f| 320-210-1830
darci@ampersandpsychology.com

To:

- ☐ Send
- ☐ Receive
- ☐ Both Send and Receive

I am authorizing the information to be shared in the following ways:

- ☐ Verbally
- ☐ Mail
- ☐ Fax
- ☐ Email

The following information:

- ☐ Attendance
- ☐ Diagnostic Assessment & Rec's
- ☐ Discharge Summary
- ☐ Progress in Treatment/Progress Notes
- ☐ Collateral Information for Assessments
- ☐ Billing/Payment Information
- ☐ All Records
- ☐ Other: ______________________

With the following person or business:

Name/Business: ____
Relationship to person or business: ____
Address: ____
Phone Number: ____
Fax Number: ____

The above information will be shared for the following purposes:

- ☐ Safety Planning
- ☐ Emergency Contact/Emergency Care
- ☐ Assessment/Treatment Planning
- ☐ Referral
- ☐ Case Review
- ☐ Coordination or Collaboration of Care
- ☐ Discussing Progress
- ☐ Discharge Planning
- ☐ Acknowledgment of Client's Services
- ☐ Insurance / Billing
- ☐ Other: ______

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1 Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after **1 year**, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Relationship to Client:
___Self
___Parent/Legal Guardian
___Other _______________

Signature: ____ Date: __________________
Printed Name: ____