

**Elevate Mental Health
Admissions & Health Information Management**

Tel: 651-317-4650 and Fax: 866-338-1322



AUTHORIZATION TO DISCLOSE HEALTH & DEVELOPMENTAL INFORMATION

Client Name (Last, First, Middle Initial)		Date of Birth	
Street Address	City	State	Zip
Day Phone #	Evening Phone #		

I authorize Elevate Mental Health to receive from or disclose my child's health & developmental information to the following person or organization:

Name:		
Program:		
Business Name (if applicable):		
Street Address:		
City:	State:	ZIP:
Telephone:	Fax:	

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

>Please check all that apply<

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Admission/Intake information/reports | <input type="checkbox"/> Diagnosis & Treatment Plan | <input type="checkbox"/> Progress/Case Notes | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychological Assessment Reports | <input type="checkbox"/> Evaluation Reports | <input type="checkbox"/> Progress Review/Reports | <input type="checkbox"/> Medical/Physical History |
| <input type="checkbox"/> Medication records | <input type="checkbox"/> Demographic Information | <input type="checkbox"/> Information required for case coordination | |
| <input type="checkbox"/> Verbal Communication (regarding): _____ | | <input type="checkbox"/> Educational Records (including IEP and IFSP) | |
| <input type="checkbox"/> Billing records/statement (dates) _____ | | | |
| <input type="checkbox"/> Other (describe): _____ | | | |
| <input type="checkbox"/> Release entire record | | | |

THE PURPOSE OF THIS AUTHORIZATION IS FOR:

>Please check all that apply<

- | | | |
|---|--|---|
| <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Third Party Authorization and Payment | <input type="checkbox"/> Communication regarding legal issues |
| <input type="checkbox"/> Insurance Payment | <input type="checkbox"/> Determination of eligibility for services | |

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that if the person or entity receiving this information is not a health plan, health care or other provider covered by federal or state privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying Elevate Mental Health child and family counseling in writing and that if I choose to do so, my request to revoke will not affect any actions taken by Elevate Mental Health before receiving my revocation. I understand that unless otherwise revoked, this authorization will expire one year from the date it is signed.

Elevate Mental Health will not refuse or restrict my treatment if I refuse to sign this authorization. A photocopy or fax of this authorization will be treated in the same manner as an original.

Client/Legal Representative Signature Date

Describe legal representative's relationship. * Elevate Mental Health reserves the right to request documentation authorizing you to act as a legal representative.

Tennessee Warning: You have a right to be told the intended use and purpose of information requested, whether or not you can legally refuse to provide the information, what might happen if you provide or refuse to give the information, and who, besides you, will be able to see the information you furnish.
Revised 11.8.11