Information Release

Authorization for use and disclosure of protected health information.
Information may include medical, psychiatric, mental health, alcohol or substance abuse records.
The individual has the right to restrict the disclosure of any of the types of information.

Last name______________ **First name**_______________ **MI** ___ **Prev. name/alias** _________________ **Birth date**____________

Your signature on this form Authorizes release of information about the person named above as follows:

Accend Services
101 West 2nd Street
Duluth, MN
P: 218.724.3122
F: 833.933.0639

◯ To release information to
and/or
◯ To receive information from

Organization ______________________________
Address ______________________________
City ____________ **State** _____ **Zip Code** __________
Phone __________ **Fax** ___________

Your reason(s) for requesting information:

◯ Treatment/care planning
◯ Service coordination
◯ Review current care
◯ Payment for services
◯ Health insurance application
◯ Application or appeal for Social Security disability benefits
◯ Legal
◯ Other (specify)_______________________________

Information requested includes:

◯ Health care assessments/exams
◯ Diagnostic/functional assessment/psych evaluation
◯ Psychological/neuro psychological testing
◯ Immunization records
◯ Radiology or lab reports
◯ Images or videos
◯ Medications list
◯ Surgical/ER/physician's orders
◯ Treatment/care/support plan
◯ Progress notes/progress reviews
◯ Discharge summaries
◯ Identify dates I have received treatment
◯ Service or health care billing records
◯ Complete & send attached forms
◯ Release copy of my ENTIRE file
◯ Release other information as indicated here: ______________

Dates of records this release covers: ________________________________ **OR** ◯ Release only most recent documents selected above.

Verbal communication: (check ONLY one)

◯ **Permission is granted for verbal communication** about my health/mental health care between parties identified above.
◯ **Exchange selected documents ONLY**. (no verbal communication)

INFORMATION REQUIRING SEPARATE RELEASE:
A release requestiong any of the above records WILL NOT include the following records.
CHECK ONLY ONE of the following & **NONE** of the above if you are requesting these records:

◯ Psychotherapy notes **OR** ◯ Chemical dependency assessment/treatment records **OR** ◯ HIV/AIDS testing results/info

By signing below, you acknowledge that:

*You are requesting the confidential information be exchanged between the agencies or persons listed.

*You may stop this consent at any time by writing to any organization, facility, &/or professional listed.

*You may inspect the records being released, or request a copy. You may be charged a fee for copies.

*You understand that once the information specified above is sent, it could be re-disclosed by the person that receives it &/or may no longer be protected by federal or state privacy laws.

*You understand that if the organizations listed are health care providers, they will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this consent form.

*If you choose not to sign this form to release information to an insurance company, your failure to sign will not impact your treatment; but that you may not be able to get new or different insurance; &/or may not be able to get insurance payment for your care.

*You understand that this consent will expire in one year from the date signed, or you may select to expire this consent on the following earlier date or event: (list date or event)

Client ___________________________ **Date** ________ **Legal Representative**__________________________ **Date**________

◯ Parent of minor ◯ Legal/court-appointed guardian/conservator (must include legal documentation if this circle is filled)

Please allow 10 days for processing.