AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ Date of Birth_____

I hereby authorize, **Innovative Psychological Consultants, 7236 Forestview Lane N., Maple Grove, MN 55369 (763-416-4167Ph 763-416-4137 Fax**) to:

____ Disclose to: ____ Receive from: ____ Exchange with:

The following organization/person:

Organization:_____
Person: _____
Address:_____
City, State, Zip:_____
Phone:_____

My Health Records from (Date)_____ to (Date)_____

Indicate below the specific health information to be disclosed:

_____
_____

Specify the reason for release of records below:

_____
_____

This authorization will expire on: Date:_____
OR When the following occurs:_____

I hereby authorize the receipt, disclosure, or exchange of my private health information as specified above. I understand that I may revoke this release at any time by sending written notification to the health care provider. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. I understand that if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I understand that my authorization is voluntary and I may refuse to sign it and my refusal will not affect my ability to obtain treatment. I also understand the following consequences may occur by refusing to sign this release: 1) If authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and 2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking.

_____ _____
Signature of Patient (or personal representative) Date

_____
Relationship of personal representative to patient (If applicable)