# MIDWEST CENTER FOR TRAUMA AND EMOTIONAL HEALING

16204 Highway 7 Minnetonka, MN 55345
Phone: 952.232.7712 Fax: 952.938.6969

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client: _____ Date: _____

Street: _____ DOB: _____

City/State:_____ Telephone: _____

I authorize_____ to obtain, release or exchange the following information for the purpose of coordinating services for the above named client.

_____ Obtain specified information for my file from the party named below.

_____ Release specified information from my file to the party named below.

_____ Exchange specified information from my file with the party named below.

Name: _____Telephone: _____

Agency/Institution: _____

Street: _____ City/State: _____

Please circle the following information to be disclosed: Oral _____ Written: _____

Phone consultation
Diagnosis
Progress Notes (including Inpatient/Outpatient summaries)
Treatment Plan
Social History
Medical/Medication History
Psychological Evaluations/Testing Reports
Discharge Summary
Social Service Reports
Medical Reports
Chemical Dependency Evaluation
Other (specify) _____

Information Restrictions: _____

I understand that this release will take effect on the date signed and will be in effect for (1) year.

I certify that this consent has been given voluntarily and that I may revoke this authorization at any time by notifying my therapist/provider in writing. In understand that my cancellation will not have any effect on information released before the provider received my written notice.

_____ Date: _____
Client Signature

_____ Date: _____
Therapist Signature

_____ Date: _____
Witness/Parent/Guardian