Authorization to Release or Exchange Protected Health Information (PHI)

Last Name: _____ First: _____ Middle: _____
Date of Birth: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Address (Street, City, State, Zip):

I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the provider named below to recipient named below.

- ☐ Diagnostic Assessment
- ☐ Psychological Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Billing Records
- ☐ Teacher, Counselor, Staff observations
- ☐ Medical Report (including related services)
- ☐ Substance Abuse Assessment/Records
- ☐ Entire Health Record *(Excludes Psychotherapy Notes)
- ☐ Special Education Records (related services)
- ☐ Probation/Court Records
- ☐ Other _____

☐ I will pick up copies of my records ☐ Mail or fax copies of my records to the individual noted below ☐ Verbal Exchange

PHI to be exchanged or released between	
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: ☐ legal ☐ referral ☐ continued medical care ☐ personal interest
☐ coordination of care with: _____ ☐ other: _____

I understand:

- I MAY REVOKE THIS Authorization at any time by providing my written revocation to this address: 199 Coon Rapids Blvd, Suite 306, Coon Rapids, MN 55433. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, FBTA may not condition the provision of treatment or payment for my care on my signing this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENSE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**
- ***The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.**
- **The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.**
- **I understand that if my records, at my request, are released, I will be charged $1.15 per page (Minnesota Statute 144.335, subdivision 5), plus postage, payable prior to the release of the requested records. (Make all checks payable to Family Based Therapy Associates). These fees have been set by the Minnesota legislature.**

_____ _____ _____
Signature of Client, Parent, or Legal Authorized Representative** **Relationship to Patient** **Date**

_____
Print Name of Client, Parent, or Legal Representative ****May be requested to show proof of representative status**

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fbta Personal, Comprehensive Mental Health Care

Cambridge Clinic 763.689.9407 (T) 763.552.0164 (F)
Coon Rapids Clinic/Administration 763.780.1520 (T) 763.780.2114 (F)
Chisago City Clinic 651.257.2733 (T) 651.257.2783 (F)