AUTHORIZATION FOR VERBAL AND WRITTEN RELEASE of Protected Health Information (PHI)

Full Legal Name: ______________________________________ Date of Birth:_____________________
Address: ____
Phone: (Hm/Wk/Cell) E-mail: ____

PHI may be exchanged between the following:

Name:	Name: Root to Crown Healing & Wellness
Address:	Address: n/a
Phone:	Phone: 612-351-0108
Fax:	Fax: n/a

I, ______________________ authorize the above parties to obtain information and/or disclose information pertaining to the following:

□ Diagnostic Assessment
□ Treatment Plan
□ Chemical Dependence Assessment
□ Progress Notes
□ Treatment Progress Summary
□ Entire Health Record (excludes notes)
□ Discharge Summary
□ Appointment History
□ Billing Records
□ Other:
□ PHI records dated from (date) to (date) maintained or created by the provider named above may be exchanged with recipient named above.

Exchange of PHI is for purposes of:

□ Care Coordination
□ Referral
□ Other:
□ Treatment Planning
□ Legal Purposes

I understand:

• I may revoke this authorization at any time by providing my written revocation to Root to Crown Healing & Wellness, LLC. 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.
• 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 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. These fees have been set by the Minnesota legislature.

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