

AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name:		Other Names Used (if any):	
Date of Birth:		Social Security Number (voluntary):	
Agency Maintaining Information: Name:		Agency Asking for Information: Name: Orr Memory & Geriatric Behavioral Clinic	
Agency Address (Street, City, State, Zip)		Agency Address (Street, City, State, Zip) 720 Main Street, Suite 204 Mendota Heights, MN 55118	
Agency Phone/Fax:		Agency Phone/Fax: (651)-528-8183 (651) 528-8184	
Information which may be released includes (check appropriate boxes): <input type="checkbox"/> ALL <input type="checkbox"/> Phone Contacts <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> Medication Information <input type="checkbox"/> History and Physical Exams <input type="checkbox"/> Psychological Tests / MMPI <input type="checkbox"/> Two-way communication between providers <input type="checkbox"/> Other _____			
All records pertaining to psychological/mental health, chemical dependency, and/or HIV/AIDS will be released unless indicated here: DO NOT RELEASE RECORDS REGARDING: <input type="checkbox"/> mental health <input type="checkbox"/> chemical dependency <input type="checkbox"/> HIV / AIDS			
Dates of Information to be Released: <input type="checkbox"/> ALL <input type="checkbox"/> Other _____			
This information may be released for the purposes of: <input type="checkbox"/> Planning or continuing my care and treatment <input type="checkbox"/> Determining eligibility for insurance benefits <input type="checkbox"/> Sharing information about my stay and treatment <input type="checkbox"/> Determining eligibility for Social Security Benefits <input type="checkbox"/> Other (specify) _____			
Your signature indicates that you know what information will be given and what it will be use for. This authorization also states that you know who will receive this information and that this information is private. A detailed description of the potential uses and disclosures of protected health information can be found in our <i>Notice of Privacy Practices</i> . You have the right to review our most updated copy of these practices before signing this consent. Your care and treatment are not dependent on your signing of this release. You acknowledge that information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be subject to federal healthcare privacy protections.			
REVOCATION CLAUSES: I understand that I may withdraw my authorization by written notice. My authorization will expire one year from the date signed if I do not revoke my consent earlier. Date of Expiration (not to exceed one year): _____			
Patient Signature:		Date:	Guardian Signature (if applicable):
Date:		Date:	
Phone Number:		Relationship to patient:	
Signature of Witness:		Date:	Reason Patient is unable to sign:

A photocopy of this release is as valid as the original