

# FULLER LIVING AND ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION		
Patient Name	Date of Birth	
Address	Phone Number	
City	State	Zip Code

INITIAL ACTION
<input type="checkbox"/> Keep on File for Future Use <input type="checkbox"/> Request records from Agency/Name Listed Below

I AUTHORIZE FULLER LIVING & Associates TO	<input type="checkbox"/> RELEASE INFORMATION TO: <input type="checkbox"/> RECEIVE INFORMATION FROM:
Agency/Name	Relationship to Patient
Phone Number	Fax Number
Address	City, State, Zip Code
Email	<input type="checkbox"/> This is my primary care provider.

INFORMATION TO BE RELEASED (CHECK APPROPRIATE BOX(ES)):	
<p><b><u>Only release Mental Health/Medical records checked below:</u></b></p> <p><input type="checkbox"/> Standard Release (Recent Intake Assessment, Last 3 Progress Notes, and Most Recent Treatment Plan)</p> <p><input type="checkbox"/> Most Recent Intake Assessment</p> <p><input type="checkbox"/> Last 3 Progress Notes</p> <p><input type="checkbox"/> Most Recent Treatment Plan</p> <p><input type="checkbox"/> Psychological Testing Interpretive Report</p> <p><input type="checkbox"/> Other (Specify Type) _____</p>	
<p><input type="checkbox"/> Or Any and All Mental Health/Medical Records Dated From:            _____ to _____</p>	

**PURPOSE OF RELEASE (CHECK APPROPRIATE BOX(ES)):**

**The purpose of this release is for coordination of care or:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Personal Use/Review*               | <input type="checkbox"/> Family Involvement     | <input type="checkbox"/> Litigation/Legal*    |
| <input type="checkbox"/> Social Security Appeal/Disability* | <input type="checkbox"/> Collateral             | <input type="checkbox"/> Continuation of Care |
| <input type="checkbox"/> Insurance Payment/Claim*           | <input type="checkbox"/> Emergency Contact Only | <input type="checkbox"/> Other* _____         |

*\*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.542.*

**METHOD OF COMMUNICATION (CHECK APPROPRIATE BOX(ES)):**

**Electronic Methods:**

- |  |   |
|--|---|
| <input type="checkbox"/> Non-Secure Email (PDF)      | <input type="checkbox"/> Secure Email (PDF) |
| <input type="checkbox"/> CD (Password-Protected PDF) |   |

**Standard Methods:**

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Phone/Email Conversation | <input type="checkbox"/> Pick Up |
| <input type="checkbox"/> Fax                      | <input type="checkbox"/> Mail    |

**NOTE:** Transmission of records via standard email is not a secure method of transmission. By choosing email, I understand that I risk my information being intercepted by an unauthorized individual.

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. Substance Use Disorder (SUD) records may not be re-disclosed to investigate or prosecute a patient. c. My SUD records are protected under the federal regulations governing confidentiality and SUD patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 164. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. e. Disclosure is only allowed with my authorization, except in limited circumstance as described in Fuller Living and Associates Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. This authorization shall be in force and effect until 1 year from the date of execution at which time this authorization expires. Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.524.

**Patient/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Representative's Relationship to Patient (Parent, Guardian, etc.): \_\_\_\_\_

**NOTE:** If signed by someone other than the patient, we need written proof of authority.

**Minor Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.**