



6600 FRANCE AVE S EDINA MN 55435 FAX 952 303 3434

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ the undersigned, hereby authorize Pinnacle Behavioral Health to:

- \_\_\_\_\_  Receive information from:
- \_\_\_\_\_  Release information to:
- \_\_\_\_\_  Release and receive information to/from:

Individual: \_\_\_\_\_ Relationship: \_\_\_\_\_

Agency: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax# \_\_\_\_\_

The confidential information to be released and/or obtained may include:

- |   |  |
|---|--|
| _____ <input type="checkbox"/> Admission/Discharge Summary      | _____ <input type="checkbox"/> Chem Dep Eval/Drug and Alcohol Info |
| _____ <input type="checkbox"/> Social History and/or Assessment | _____ <input type="checkbox"/> Lab/Drug Screen Results             |
| _____ <input type="checkbox"/> Psychiatric Evaluations          | _____ <input type="checkbox"/> Treatment Plan/Summary              |
| _____ <input type="checkbox"/> Case Notes                       | _____ <input type="checkbox"/> Progress Summary                    |
| _____ <input type="checkbox"/> Legal Records                    | _____ <input type="checkbox"/> Physician Notes                     |
| _____ <input type="checkbox"/> Diagnostic Assessments           | _____ <input type="checkbox"/> Other: _____                        |

Use of this information shall be limited to the following purpose(s):

- |   |   |
|---|---|
| _____ <input type="checkbox"/> Treatment Planning             | _____ <input type="checkbox"/> Coordination of Services     |
| _____ <input type="checkbox"/> Determine Vulnerability Issues | _____ <input type="checkbox"/> Continuation of Medical Care |
| _____ <input type="checkbox"/> Legal Specify: _____           | _____ <input type="checkbox"/> Funding/Financial            |
|   | _____ <input type="checkbox"/> Other: _____                 |

Information/ communication may be released to the above individual/ facility through:

- \_\_\_\_\_  Fax    \_\_\_\_\_  Telephone    \_\_\_\_\_  Mail    \_\_\_\_\_  Other: \_\_\_\_\_

I understand I may cancel/modify this release at anytime. Cancellation/modification will not be retroactive.  
 I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.  
 This authorization will take effect on the date signed and shall remain valid until: \_\_\_/\_\_\_/\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date in which it has been signed.  
 I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.  
 Federal Law regulations prohibit further disclosure of release of information without patient's specific written notice or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date