Fax: 952-235-6738

Pinnacle
Behavioral Healthcare
Exceptional Care, Compassionate People

2800 County Road 42, Suite 217
Burnsville, MN 55337

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:

_____ ☐ Admission/Discharge Summary
_____ ☐ Social History and/or Assessment
_____ ☐ Psychiatric Evaluations
_____ ☐ Case Notes
_____ ☐ Legal Records
_____ ☐ Diagnostic Assessments
_____ ☐ Chem Dep Eval/Drug and Alcohol Info
_____ ☐ Lab/Drug Screen Results
_____ ☐ Treatment Plan/Summary
_____ ☐ Progress Summary
_____ ☐ Physician Notes
_____ ☐ Other:_____

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

_____ ☐ Treatment Planning
_____ ☐ Determine Vulnerability Issues
_____ ☐ Legal Specify:_____
_____ ☐ Coordination of Services
_____ ☐ Continuation of Medical Care
_____ ☐ Funding/Financial
_____ ☐ 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