CORE *Professional Services, P.A.*

□Brainerd Office: 617 Oak Street, Brainerd, MN 56401 Ph: (218) 829-7140 Fax: (218) 829-7124
□Sartell Office: 110-14th Avenue East, Sartell, MN 56377 Ph: (320) 202-1400 Fax: (320) 202-8662
□Mankato Office: 209 S. 2nd Street, Suite 300, Mankato, MN 56001 Ph: (888) 833-2859 Fax: (218) 818-6726

Authorization Form

This form, when completed and signed by you, authorizes CORE Professional Services to release protected information from your clinical record, or the clinical record of your child, or of someone for whom you are the appointed guardian or for whom you are the legal representative, to the person or agency you designate. This form also authorizes CORE Professional Services to receive information from the designated person or agency.

_____

(Patient Name) (Date of Birth)

I authorize CORE Professional Services, P.A. and/or its professional, administrative and clinical staff to *(circle yes or no)*

YES NO release information to and/or
YES NO receive information from

(Check all that Apply)

_____ Social History and Contacts with Social Services
_____ Information Regarding Chemical Dependency Treatment or
_____ Issues Any Information Pertinent to Assessment and Counseling
_____ Educational Information
_____ Other Progress Notes
_____ Treatment Summary
_____ Financial/Billing Information/ Credit Card Payments
Cardholder name:
Cardholder signature:
Cardholder DOB or last four digits of SS #:

_____ Diagnostic Assessment/Evaluation
_____ Psychological Testing Results
_____ School Adjustment Information
_____ Psychiatric Reports
_____ Quarterly Reviews
_____ Discharge Summary
_____ Criminal History
_____ Other: _____

Additional explanation of the listed items, above, will be provided upon request.

This information should only be released to and/or obtained from:

_____ _____

(Name) (Address)/(Phone)/(Fax)

I am requesting this information to be released and/or received for the following reasons/purposes:
Coordination of services

If no purpose is stated, the information will be released at the request of the patient or authorized representative.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to CORE's office address. However, your revocation will not be effective to the extent that CORE and/or its professional, administrative and clinical staff has/have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that CORE generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that no other uses will be made of this information, except those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purpose stated above. I understand that I may revoke this consent at any time and that, in any event, it expires automatically as described below.

This authorization shall remain in effect until_____/_____/_____, one year from the date of the authorization.

_____ _____ _____

Signature of patient, legal guardian, or authorized representative PRINT NAME PLEASE Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. (Example-"parent" or "conservator")

(A photocopy/facsimile of this authorization is valid as original).