CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

1600 University Avenue West, Suite 12, Saint Paul, Minnesota 55104 • Office – 651-379-5157 • Fax – 651-379-5159

CLIENT'S NAME:_____ DATE OF BIRTH: _____

I HEREBY AUTHORIZE NATALIS COUNSELING & PSYCHOLOGY SOLUTIONS TO:

□ RELEASE INFORMATION TO □ VERBALLY EXCHANGE WITH □ OBTAIN INFORMATION FROM □ FACSIMILE

NAME OF AGENCY/INDIVIDUAL: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PURPOSE OF RELEASE:

□ COORDINATION OF CARE □ TRANSFER OF CARE □ INSURANCE □ PERSONAL USE □ OTHER: _____

PLEASE CHECK SPECIFIC INFORMATION AUTHORIZED TO RELEASE/OBTAIN:

□ Intake Summaries
□ Social History
□ Treatment Plans
□ Therapy Progress Reports
□ Discharge and Closing Summaries
□ Psychological Tests/Evaluation Reports
□ Vocational Evaluation Reports
□ Admission History and Evaluations/Assessments
□ School Records
□ Court Report/Custody Studies
□ Other, specify: _____
□ Medical Reports/Physical Exams (include diagnosis/prognosis)
□ Psychiatric Evaluations (include diagnosis/prognosis)
□ Lab Reports
□ Progress Reports
□ Aftercare Plan
□ Chemical History/Assessment
□ Speech □ OT □ PT

This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by myself in writing. I understand that, except for research-related treatment, Natalis Counseling & Psychology Solutions will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. This authorization for disclosure of information has been fully explained to me and I understand it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires within one year. The consent will last no longer than reasonably necessary to serve the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (if applicable) Date

_____ _____
Witness (Verbal Authorization Only) Date

_____ _____
Witness (Verbal Authorization Only) Date

INTERNAL USE ONLY: □ Scan Only □ Fax & Scan □ Mail & Scan Clinician: _____ and/or Care Manager: _____