



# CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

1600 University Avenue West, Suite 12, Saint Paul, Minnesota 55104 1310 Hwy 96 East, Suite 200, White Bear Lake, Minnesota 55110  
1360 Energy Park Drive, Suite 340, Saint Paul, Minnesota 55108 7582 Currell Boulevard, Suite 208, Woodbury, Minnesota 55125  
• Office: 651-379-5157 • Fax: 651-379-5159 • Email: MedicalRecords@natalispsychology.com •

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: \_\_\_\_\_

EMAIL: \_\_\_\_\_

## PURPOSE OF RELEASE:

- COORDINATION OF CARE     TRANSFER OF CARE     INSURANCE     PERSONAL USE     OTHER: \_\_\_\_\_

## PLEASE CHECK SPECIFIC INFORMATION AUTHORIZED TO RELEASE/OBTAIN:

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

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     Scan & Fax     Scan & Mail  
RECORDS REQUEST:     Pick Up     Mail     Email     Fax    Clinician: \_\_\_\_\_ and/or Care Manager: \_\_\_\_\_