Release Of Information

Eclectic Therapy Collective
119 4th St S, Moorhead, MN 56560

Client Information
Full Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email: _____

2. Purpose of Release
I authorize Eclectic Therapy Collective to release and/or receive my protected health information (PHI) for the purpose of:

[ ] Care Coordination
[ ] Insurance/Payment Purposes
[ ] Legal Purposes
[ ] Emergency Contact
[ ] Personal request
[ ] Other: _____

3. Recipient Information
Name/Organization: _____
Address: _____
Phone/Fax: _____
Email (if applicable): _____

4. Information to Be Released
[ ] Most Recent Health Information (Diagnostic Assessment, Treatment Plan, Last 3 Progress Notes)
[ ] Most Recent Diagnostic Assessment
[ ] Most Recent Treatment Plan
[ ] Most Recent Progress Notes (Last 3)
[ ] Diagnosis
[ ] Discharge Summary
[ ] Other: _____
OR
[ ] Specific dates/years of treatment listed below (This will authorize all medical records to be released that were created within the timeframe listed below. Any records created outside of the timeframe you state below WILL NOT be released)

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5. Method of Release
[ ] Mail
[ ] Fax
[ ] Email (secure)
[ ] In-person pick-up
[ ] Other: _____

6. Expiration and Revocation
This authorization will expire on: _____

I understand that I may revoke this authorization at any time by providing written notice to Eclectic Therapy Collective. Revocation will not affect disclosures made prior to receipt.

7. Authorization and Understanding
I understand and acknowledge the following:
Privacy Protections: My health information is protected under HIPAA (45 CFR), 42 CFR Part 2 for alcohol and drug abuse records, and applicable state laws. Disclosure requires my authorization except in limited circumstances described in Eclectic Therapy Collective's Privacy Notice.
Right to Revoke: I may revoke this authorization at any time except to the extent action has already been taken in reliance on it. Revocation procedures are outlined in the Privacy Notice. Unless otherwise specified, this authorization expires one year from the date of signing.
Voluntary Authorization: For disclosures beyond treatment, payment, and healthcare operations, my consent is voluntary. Treatment will not be conditioned on signing this form, except when services are provided solely to create protected health information for disclosure to a third party.
Communication Disclosure: Communications resulting from this authorization may indicate that I receive services at Eclectic Therapy Collective.
Re-Disclosure: Federal regulations prohibit re-disclosure of alcohol and drug abuse records (42 CFR Part 2). However, information disclosed under HIPAA may be subject to re-disclosure by the recipient and no longer protected.
Program Transfers: This authorization may also apply if I transfer care to other programs owned or managed by Eclectic Therapy Collective.

7. Signatures

Client/Legal Guardian: _____ Date:_____
Relationship to Client (if signed by guardian): _____

Optional Notes/Instructions

_____