

Behavioral Health Services

Eagan
Yankee Square Office III
3460 Washington Dr
Suite 200
Eagan, MN 55122
(651) 769-6200
(651) 769-6249 Fax

Fridley
6401 University Ave NE, Suite 304
Fridley, MN 55432
(763) 769-6250
(651) 769-6299 Fax

Golden Valley
8085 Wayzata Blvd, Suite 101
Golden Valley, MN 55426
(651) 769-6300
(651) 769-6349 Fax

North St. Paul
2497 7th Ave E, Suite 101
North St. Paul, MN 55109
(651) 769-6400
(651) 769-6449 Fax

Shakopee
327 Marshall Road S, Suite 250
Shakopee, MN 55379
651-769-6500
(651) 769-6549 Fax

Woodbury
7616 Currell Blvd
Suite 290
Woodbury, MN 55125
(651) 769-6550
(651) 769-6599 Fax

Authorization for Release of Confidential Information

I, _____

Authorize Behavioral Health Services to:

- ___ disclose information to
- ___ obtain information from
- ___ exchange information with

(Name of Person or Agency)

(Address)

Regarding: myself, _____

son/daughter; _____

other; _____

Date of Birth: _____

Treatment date(s) from _____ to _____

The information to be disclosed is:

- | | |
|--|---|
| <input type="checkbox"/> Diagnostic Impressions | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Treatment Summary | <input type="checkbox"/> Medication History |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> HIV/AIDS Records |
| <input type="checkbox"/> Medical History/ | <input type="checkbox"/> Reproductive Health |
| <input type="checkbox"/> Physical Examination | <input type="checkbox"/> Academic Record/School Functioning |
| <input type="checkbox"/> Court Evaluations and/or Dispositions | |
| <input type="checkbox"/> Other: _____ | |

The purpose of the disclosure is: _____

I understand that I may revoke this consent at any time by written notice. Without an expressed revocation (unless information has already been released) it will expire after twelve months. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that BHSI may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

(Date)

(Signature of Patient, Parent or Guardian)

(Signature of Witness)