

Authorization for Access to Patient Health Information

Patient Information

Full Name

Maiden or Previous Name

Date of Birth

Phone Number:

Street Address

City, State, Zip

Release Information

Authorization From:

The Remedy Mental Health

Name

3555 Willow Lake Blvd., Suite 290

Street Address

Vadnais Heights, MN 55110

City, State, Zip

(952) 431-5330

(952) 431-5334

Phone Number

Fax Number

Release Information To:

Name

Street Address

City, State, Zip

Phone Number

Fax Number

Authorization

I AUTHORIZE AND GIVE PERMISSION FOR THE ABOVE INDIVIDUAL TO:

- Discuss patient health information and care with providers and/or medical assistants.
- Request copies of all patient medical records.
- Create and change appointments.
- Discuss patient's billing information including balances, charges, insurance, and payments.
- Other (please specify): _____

This authorization expires in one year from the patient/patient representative date of signature unless revoked by patient/legal guardian before that time.

Return to: The Remedy Mental Health, 3555 Willow Lake Blvd, Ste. 290, Vadnais Heights, MN 55110, or Fax: 952-431-5334.

Include a copy of a valid form of ID: Driver's License Government Issued ID
 Military ID Passport

Patient Signature or Representative

Relationship (if other than patient) _____

Date _____

2/17/2026