THE REMEDY MENTAL HEALTH

Phone: (952) 431-5330
Fax: (952) 431- 5334
3555 Willow Lake Blvd., Suite 290
Vadnais Heights, MN 55110

Authorization for Use and Disclosure of 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:

Name

Street Address

City, State, Zip

Phone Number *Fax Number*

Release Information To:

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*

Method of Delivery (Check all that apply)

☐ US Mail ☐ Patient Portal ☐ Fax: (952) 431-5334

☐ Email (Secure): _____

☐ In-Person Pick-Up (Maple Grove, Hudson etc): _____

Information to be Released:

☐ **Entire Record OR** choose from the following:

☐ Specific Dates of Service _____

☐ Behavioral/Mental/Psychiatric Health Notes
☐ Clinic/Therapy Notes
☐ Substance Abuse Treatment Records
☐ Laboratory Tests/EKG/ Imaging Tests
☐ In-patient Records
☐ Medication List
☐ Treatment Plans
☐ Hospital Records
☐ MRI Reports
☐ Discharge Summary

Purpose of Disclosure (Check all that apply)

- ☐ Personal Request
- ☐ Continuity of Care
- ☐ Legal
- ☐ Insurance
- ☐ Transfer of Care (to another facility)
- ☐ Other _____

Return to: The Remedy Mental Health C/O Health Information 3555 Willow Lake Blvd., Suite 290 Vadnais Heights, MN 55110 or Fax: (952) 431- 5334

Expiration of Authorization

This authorization will expire 1 year from date of signature unless another date is specified:

☐ **By checking this box, I authorize ongoing exchange of information between the above parties and the release of records for any future visits or services after the date of my signature, until this authorization expires or is revoked.**

Patient Rights Regarding Authorization

I authorize The Remedy Mental Health to release the health information selected above. I understand that:

- I may revoke this authorization at any time by submitting a written request, except for information already released or when required by law for insurance purposes.
- My treatment, payment, or eligibility for services will not be affected by my decision to sign this form, unless the service is provided solely to share information with a third party.
- Information released may be re-disclosed and may no longer be protected by federal privacy laws, except for alcohol or drug treatment records, which remain protected under 42 CFR Part 2.
- I may request and receive a copy of this authorization and the records released, consistent with applicable law.
- A copy of this authorization is as valid as the original.

Note: *A patient (18 years or older) must authorize the release of their own information. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require a minor's authorization.*

_____ _____

Patient/ Guardian Signature **Printed Name**

_____ _____

Relationship (if not patient) **Date Signed**

(legal documentation of access by the signing individual may be required)