Independent Healthcare Resources. (IHR)

Please send requested info to: Independent Healthcare Resources. 1619 Dayton Ave
Suite 317 Saint Paul, MN 55104 phone: (651) 645-1090 | Fax: (651) 645-5168

Release of Information Client Authorization for Release of Protected Health Information

Client First Name: **Client Last Name:** **DOB:**

Phone: **Email:**

1a. I authorize the disclosure and use of my protected health information by Independent Healthcare Resources as notes below to:

Obtain from ☐ Give to ☐ Talk with ☐

1b. I authorize the organization/person(s) listed below to disclose information to Independent Healthcare Resources.
Name:

Phone Number:

2. This Information may be released and used for the following purposes: ☐ **ALL SERVICES (or)**

☐ Confirm Diagnosis ☐ Allowing for coordination of services
☐ Determine Program/Service Eligibilit ☐ Treatment Planning
☐ Discharge Planning ☐ Emergency Contact ☐ Other:

3. Protected Information that may released and used: ☐ **ALL RECORDS (or)**

☐ Psychological Evaluation ☐ Functional Assessment CD History and Assessment
☐ CD Treatment Records ☐ Psych Evaluation & Diagnosis ☐ Diagnostic Assessment
☐ Medical Records ☐ Crisis Plan ☐ Other:

4. Information to be released covers the following dates:

Records dates from: Start Date: End Date:

****I understand that this release may cover information that is created after the date of my signature below:**

5. This release expires one year after the date you sign it unless a different date of expiration is entered here.

Expiration Date: 6. I acknowledge as follows:

- I May revoke my authorization in writing at any time. I understand that my revocation must be in writing, signed by me and sent to the IHR at the address listed above either by fax or mail. My revocation does not/ cannot apply to Information already disclosed under this authorization.
- My information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse;
- My information may include records received from other organizations if these records have been used as are part of the medical records maintained by IHR and may be released with my Information.
- IHR cannot prevent redisclosure of my Information by the person or organization that receives my records and once released, Information may lose state and federal privacy protection. By signing this authorization, I release IHR from any liability resulting from the redisclosure by the recipient.
- I may ask for a copy of IHR's privacy Notice if I need more information.

My Signature indicates that I have read and understand this form, accept its terms and authorize release of my information as described above.

Staff Signature:_____ **Client Signature:** _____