

Aurora Psychological Services

4660 Slater Road, Suite 210

Eagan, MN 55122

Phone: 651-882-6299 FAX: 651-683-0057

AUTHORIZATION FOR RELEASE OF INFORMATION

This form, when completed and signed by you, authorizes Aurora Psychological Services to release protected health information about you or your child.

Client's Name: _____

Client's Date of Birth: _____

Client's Address: _____

Client's Telephone Number: _____

I authorize Aurora Psychological Services to release and obtain the following information:

- | | | |
|--|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Verbal information (two-way) | <input type="checkbox"/> Psychological Evaluations |
| <input type="checkbox"/> Progress to Date | <input type="checkbox"/> Treatment Plans/Summaries | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Frequency of Treatment Received | <input type="checkbox"/> Type of Treatment Received | |
| <input type="checkbox"/> Other _____ | | |

This information is being released for the purpose of _____.

This information should only be released to or obtained from (circle appropriate) the following person/s:

Name: _____

Title: _____

Address: _____

Phone: _____

This authorization shall remain in effect until _____ (date).

I understand that I have the right to cancel this authorization, in writing, at any time by sending or giving such written information to my psychologist. However, my cancellation will not be effective to the extent that my psychologist has already taken action relying on this authorization. I understand that information used or disclosed that is related to this authorization may be subject to re-disclosure by the recipient of the information and is not longer protected by the HIPAA Privacy Rule.

Signature of Patient/Guardian

Date

Authority of personal representative or guardian to act on behalf of the patient: _____