# Oak Ridge Center

14665 Galaxie Ave., Suite 140, Apple Valley, MN 55124 (952) 431-6033 Fax: (952) 431-3225

## Consent for Release of Protected Health Information

I hereby authorize **Protected Health Information (PHI)** from the health record(s) of:

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

To be exchanged **(check all that apply)** via mail, fax, or verbally

- ☐ **Sent to Oak Ridge Center from** the party below
- ☐ **Sent from Oak Ridge Center to** the party below
- ☐ **Ongoing Communication with Oak Ridge Center** and the party below

Name: _____

Organization: _____

Relationship to Client: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

**PHI to be exchanged:**

☐ Complete Record ☐ Discharge Summary ☐ Initial Evaluation ☐ Scheduling Appointments

☐ Testing ☐ Billing/Payment ☐ Psychotherapy Progress Notes ☐ CD Evaluation/Treatment Records

☐ Other, Specify: _____

**Date(s) of treatment from: _____ to _____**

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in compliance of this consent. This authorization will be effective for medical/treatment records generated to the date of the signature, and the release of medical records created after the date of the signature until the expiration date or the release is revoked in writing or as otherwise specified. If revocation is not received, authorization will be considered valid for a period of one year.

The facility, its employees, officers, and attending physician are released from legal responsibility or liability for the release of the above PHI to the extent indicated and authorized herein.

I understand that the PHI released could contain reference to Substance Abuse, Psychological and/or Psychiatric Impairment. The information disclosed is restricted to the minimum amount necessary to accomplishment the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization.

I understand that, except for research related treatment, Oak Ridge Center will not condition my treatment, payment, enrollment, or eligibility for benefits for signing this authorization. This authorization for disclosure of information has been fully explained to me and I understand it.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____