Elizabeth Flynn, PLLC
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St. Cloud, MN 56303
Phone: 320-356-0197 Fax: 320-316-3560

Authorization Form

This form authorizes Elizabeth Flynn PLLC, to release protected health information from your clinical record, or the clinical record of your child, or someone for whom you are the appointed guardian or legal representative, to the person or agency you designate.

Patient Name:____ DOB:________________

I authorize Elizabeth Flynn PLLC,
To release information to___YES___NO To receive information from___YES___NO

Person/facility:____Phone:__________________

Address:____Fax:____________________

___Social History/Contacts with Social Services
___Information regarding chemical dependency treatment or issues
___Educational information
___Progress notes
___Treatment summary
___Diagnostic Assessment/Evaluation
___Psychological testing results
___School Adjustment Information
___Psychiatric Reports
___Quarterly Reviews
___Discharge Summary
___Criminal History
___Mental Health Records
___Medical Records
___Other

I am requesting this information to be released and/or receive for the following reasons/purposes:____

This information is for all dates of services unless specified here:____

*I may revoke this authorization at any time. You may not revoke if the practice is relying on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage.

*I understand if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.

*I understand that Elizabeth Flynn PLLC will not release any records from a third party

*I understand that Elizabeth Flynn PLLC generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

*I understand that no other uses will be made of this information, except those previously communicated to me or as otherwise authorized by law and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purpose state above.

*I understand that a photocopy/facsimile of this authorization is as valid as the original.

This authorization is in effect until ______________________________, one year from the date of the authorization.

____
(Client/Parent/Guardian Signature) (Date)

____
(Witness Signature) (Date)