

Rebecca Hoffman, PLLC

3400 1st Street North, Suite 300 St. Cloud, Minnesota 56303

Phone: 320-356-0308

Gratitudecounseling.com

Fax: 320-316-3560

Authorization Form

This form authorizes Rebecca Hoffman 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 Rebecca Hoffman PLLC,

To release information to ___ YES ___ NO

To receive information from ___ YES ___ NO

Person/facility: _____ Phone: _____

Address: _____ Fax: _____

___ Social History/Contacts with Social Services

___ School Adjustment Information

___ Information regarding chemical dependency
treatment or issues

___ Psychiatric Reports

___ Educational information

___ Quarterly Reviews

___ Progress notes

___ Discharge Summary

___ Treatment summary

___ Criminal History

___ Diagnostic Assessment/Evaluation

___ Mental Health Records

___ Psychological testing results

___ 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 Rebecca Hoffman PLLC will not release any records from a third party

*I understand that Rebecca Hoffman 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)