Northland Psychological Services

AUTHORIZATION FOR THE USE OR DISCLOSURE OF
TREATMENT RECORDS

_____ _____-_____-_____ _____
Client Name Date of Birth ID No.

Person or Organization Disclosing the Information

_____
_____
_____

Person or Organization Receiving the Information

Northland Psychological Services
1707 Miller Trunk Hwy
Duluth MN 55811

( ) ____ I here by authorize the EXCHANGE of the following information between the above named parties.

Description of Information to be disclosed:	Between the Dates of:
☐ Diagnostic Intake/Assessment	_____to_____
☐ Psychiatric Evaluation	_____to_____
☐ Treatment/Procedure Notes	_____to_____
☐ Psychotherapy Notes	_____to_____
☐ Diagnostic Test Reports	_____to_____
☐ Discharge Summary	_____to_____
☐ Medical Records	_____to_____
☐ Other _____	_____to_____

The purpose of this request is:

- ☐ Continuing Care/Treatment Planning
- ☐ Psychological Assessment
- ☐ Payment of Claim
- ☐ School
- ☐ Workers Compensation
- ☐ Legal
- ☐ Record of Client Obtaining Assessment/Treatment Records
- ☐ Other_____

****This authorization will expire on _____-_____-_____OR upon DISCHARGE.**

- I hereby authorize the use or disclosure of my protected health information as specified above including but not limited to ***information relating to Medical Records, Substance Abuse & Behavioral Health.***
- I understand that this authorization is voluntary and that I may refuse to sign it.
- I understand that I may revoke this authorization at any time by giving written notification to Dr. Rose-Carlson or support staff and such revocation will not affect any action taken in reliance to authorization prior to the revocation.
- Other limitations on my right to revoke this authorization may be found in the Notice of Privacy Practices.
- I understand that if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.
- I understand that treatment may not be denied if I refuse to sign this authorization.
- I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

_____ _____
Signature of Client or Personal Representative Date

Relationship of Personal Representative to the Client: _____

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