AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient	Name: _____ Previous Name(s): _____ DOB: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
	Dakota Child and Family Phone: 651-209-8640 2530 Horizon Drive Fax: 651-209-8690 Burnsville, MN 55337
Release To	Agency/Individual: _____ Relationship: _____ Fax: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
Reason for Release	Treatment/Continue Care x Transfer of Care Personal Legal Disability Determination Insurance Other: _____
How to Release Records	x Written
Date Range	O Past Two Years of Records OR O Date Range: _____ Records needed by date (please allow up to 30 days): _____
Records to be Released	**Medical Records** O ANY AND ALL MEDICAL RECORDS O Medical Notes and Procedures O Immunizations O Radiology Reports O Operative Reports O HIV/AIDS Testing and Results O Other: _____
	Behavioral Health Records O Psychiatry Dates: _____ O Psychotherapy Dates: _____ O Alcohol, Drug, or Substance Abuse Records Dates: _____ O Other: _____
	Account Records O Billing Statements O Other: _____

This authorization is valid for one year after the signed date unless specified here._____I may terminate thisauthorization in writing at any time. A termination will not change releases that happened before notice of termination. Written termination of this authorization must be turned into the Medical Records Department, along with any questions regarding the authorization. I understand that signing this authorization is voluntary. I can refuse to sign the authorization. I need not sign this authorization in order to assume treatment. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. A photocopy of this authorization may be treated in the same manner as the original. My signature indicates that I have read and understand this form, and that I authorize the release of information as described above.

O Patient (18 or older) O Parent of Minor O Legal Guardian

If the patient is **17 years of age or younger**, the patient's parent or legal guardian must sign and date this form. If a Behavioral Health patient is **16 or 17 years of age,** both the patient and their parent or legal guardian must sign and date this form.

_____	_____	_____
Patient Signature	Print	Date
_____	_____	_____
Parent/Legal Guardian Signature	Relationship	Date