

**AUTHORIZATION FOR RELEASE OF PROTECTED
 HEALTH INFORMATION**

Name (First, Middle, Last)	Birth Date (Month, DD, YYYY)
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Release Information From:

SPOT Rehab & Home Health, 2835 W. St Germain St., Suite 300, St. Cloud, MN 56301, Phone(320)259-4151 or Fax (320)259-5707

Other (Specify facility/individual & address below, including phone/fax if known.)

Release Information To:

SPOT Rehab & Home Health, 2835 W. St Germain St., Suite 300, St. Cloud, MN 56301, Phone(320)259-4151 or Fax (320)259-5707

Other (Specify facility/individual & address below, including phone/fax if known.)

Purpose of Release

<input type="checkbox"/> Treatment/Continued care	<input type="checkbox"/> Personal*	<input type="checkbox"/> Legal purposes*
<input type="checkbox"/> Disability determination	<input type="checkbox"/> Payment	<input type="checkbox"/> Other*
* Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524		

Information To Be Released

(Required—Check all that apply)

<input type="checkbox"/> Clinic notes	<input type="checkbox"/> Testing	<input type="checkbox"/> Coordinate Services	<input type="checkbox"/> Initial Evaluation
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Billing information	<input type="checkbox"/> Other (specify information to be released below)

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I understand that I may revoke this authorization at any time by notifying the providing person/ organization in writing, but if I do, it won't have any affect on any actions they took in reliance to this authorization before they received the revocation. I understand that, if the person/organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and no longer be protected by federal privacy regulations. I understand that the health care provider or health plan disclosing the information may not require me to sign this authorization as a condition of receiving treatment or payment, or health plan enrollment or benefit eligibility.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
 - Legal Guardian or Conservator
 - Health Care Agent (Health Care Power of Attorney)
- If the patient is 17 years of age or younger, the patient's parents or legal guardian must sign and date the form, unless an exception exists under federal law. Please indicate your relationship:
 - Parent
 - Legal Guardian

Signature (Required)	Date Signed (Required) (Month DD,YYYY)
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Printed Name of Person Signing (If Not Patient)