AUTHORIZATION FOR RELEASE AND DISCLOSE HEALTH INFORMATION

Name (*First, Middle, Last*)	Birth Date (*Month, DD, YYYY*)

Release Information From:

❑SPOT Rehab & Home Health, 2835 W. 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.)

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Release Information To:

❑SPOT Rehab & Home Health, 2835 W. 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.)

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Purpose of Release

❑Treatment/Continued care	❑Personal *	❑Legal purposes *
❑Disability determination	❑Payment	❑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) ❑Clinic notes ❑ Testing ❑Initial Evaluation ❑Coordinate Service

❑Progress Notes ❑Discharge summary ❑Billing information ❑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 ma 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 o 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. Pleas 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 exits under or federal law. Please indicate your relationship:
  - ❑ Parent ❑ Legal Guardian

Signature (Required)	**Date Signed** (Required) (Month DD,YYYY)

Printed Name of Person Signing (If Not Patient)