ACUMEN
COUNSELING SERVICES, LLC

Authorization For Disclosure of Client Information

Full Name:_____ Date of Birth: _____

	Release Information From:		Release Information To:
	Acumen Counseling Services, LLC 902 E. 2nd Street; Suite 326 Winona, MN 55987		
			Acumen Counseling Services, LLC 902 E. 2nd Street; Suite 326 Winona, MN 55987

Health information includes written and oral information:
If you do not want to give your permission for verbal/oral communication about your health information, initial here: _____

Purpose of the Release:

___ Treatment/Continued Care ___ Application for Insurance ___ Legal Purposes ___ Personal
___ Payment of Insurance Claim ___ Disability Determination ___ Changing Therapist ___ Other (specify):

_____

Information to be Released:

For all dates of service, unless initialed here: _____ FROM _____ TO _____
___ All records relating to Mental Health/Psychiatric Care ___ All records relating to Chemical Dependency/Abuse Treatment
___ Diagnostic/Psychological Assessments ___ Discharge Summary ___ Prescriptions
___ Client History/Consultation Reports ___ Progress/Case Notes ___ Complete Health Records

___ Other: _____

I understand that except for psychotherapy notes (which are not included in my medical record), all records of treatment for mental health, chemical dependency/abuse, sickle cell anemia, genetic conditions and AIDS/HIV will be released, unless otherwise specified. If I don't want these to be released, I will place my initial here: _____, indicating that I do not want the following records released:

_____

Revocation of this authorization must be made in writing to the provider/agency releasing the information. This authorization expires one year after I sign it, unless I indicated an earlier date or event here:

_____

I may be responsible to pay a fee for releasing these records. Once the records are released, the provider or agency releasing my records cannot prevent them from being released to a third party, and the records may no longer be protected by state and federal privacy laws. Treatment will **NOT** be conditioned upon the completion of this authorization form. To be valid, this form must be filled out completely and signed. A copy or facsimile is valid if it has not been altered.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If Applicable)

Parent/Guardian Printed Name: _____
(If Applicable)