RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER, LLC

8640 Eagle Creek Cr., Savage, MN 55378
Phone: 952-746-7664 Fax: 952-224-4867

AUTHORIZATION TO RELEASE INFORMATION

<table>
<tr><td>CLIENT INFORMATION:</td><td colspan="2">Name: ______________________ Date of Birth: ____________
Address: ______________________ Phone: ____________
City: ______________________ State: ________ Zip: ____________</td></tr>
<tr><td><u>I authorize this clinic to:</u>
☐ Send
☐ Receive
☐ Exchange</td><td colspan="2">River Valley Behavioral Health & Wellness
8640 Eagle Creek Cir, Savage, MN 55378
P: 952-746-7664 F: 952-746-0582
Provider(s):______________________</td></tr>
<tr><td><u>I authorize this clinic/organization/person to:</u>
☐ Send
☐ Receive
☐ Exchange</td><td colspan="2">CLINIC/ORGANIZATION/PERSON: ______________________
Address: ______________________
City: ______________________ State: ________ Zip: ____________
Phone: ______________________ Fax: ______________________
Email Address: ______________________
☐ I am requesting these records for myself as the client</td></tr>
<tr><td>INFORMATION TO BE RELEASED via:
☐ Fax
☐ Mail (Certified w/ fee)
☐ Email (Encrypted)
☐ Verbal</td><td>Include Exclude
☐ ☐ Discharge Summary/Plan
☐ ☐ History & Physical
☐ ☐ Laboratory Reports
☐ ☐ Hospital Records
☐ ☐ Medication Records
☐ ☐ Office/Chart Notes
☐ ☐ Psychological Test Results
☐ ☐ Chem. Dependency Treatment
☐ ☐ Chem. Dependency Diagnosis</td><td>Include Exclude
☐ ☐ Behavioral & Mental Health Records
☐ ☐ Psychological Reports
☐ ☐ Behavioral Programs
☐ ☐ In Patient/Outpatient Treatment Programs
☐ ☐ Sexuality
☐ ☐ HIV/AIDS status
☐ ☐ Pregnancy Status and Contraceptive Use
☐ ☐ Other: ____________
**Release of Psychotherapy Notes requires a separate authorization.</td></tr>
<tr><td>PURPOSE FOR RELEASE OF INFORMATION:</td><td colspan="2">☐ Planning Treatment or Program ☐ Legal
☐ Continuing Care ☐ Social Security Disability
☐ Other: ______________________</td></tr>
<tr><td></td><td colspan="2">I understand this authorization is voluntary and lasts for one year after the date I sign it unless I enter a different date here: __________. This authorization can be cancelled in writing at any time. A cancellation will not change releases that occur before the cancellation date. A photocopy/fax of this authorization will be treated the same as an original. River Valley Behavioral Health & Wellness Center, LLC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization. By signing this authorization, you release River Valley Behavioral Health & Wellness Center, LLC from any and all liability resulting from re-disclosure by the recipient. Your signature indicates you have read and understand this form, and authorize release of your information as described above.</td></tr>
</table>

Client Signature: ______________________ Date: ____________

Parent/Legal Guardian Signature: ______________________ Date: ____________