RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

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

AUTHORIZATION TO RELEASE INFORMATION

CLIENT INFORMATION:	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
I authorize this clinic to: ☐ Send ☐ Receive ☐ Exchange	River Valley Behavioral Health & Wellness 8640 Eagle Creek Cir, Savage, MN 55378 P: 952-746-7664 F: 952-746-0582 Provider(s):_____
I authorize this clinic/organization/person to: ☐ Send ☐ Receive ☐ Exchange	CLINIC/ORGANIZATION/PERSON: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email Address: _____ ☐ **I am requesting these records for myself as the client**

INFORMATION TO BE RELEASED via:

☐ Fax
☐ Mail (Certified w/ fee)
☐ Email (Encrypted)
☐ Verbal

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

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.

PURPOSE FOR RELEASE OF INFORMATION:

☐ Planning Treatment or Program ☐ Legal
☐ Continuing Care ☐ Social Security Disability
☐ Other: _____

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.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____