



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

AUTHORIZATION TO RELEASE INFORMATION

<p>CLIENT INFORMATION:</p>	<p>Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____</p>												
<p>I authorize this clinic to:</p> <p><input type="checkbox"/> Send <input type="checkbox"/> Receive <input type="checkbox"/> Exchange</p>	<p>River Valley Behavioral Health & Wellness 8640 Eagle Creek Cir, Savage, MN 55378 P: 952-746-7664 F: 952-746-0582 Provider(s): _____</p>												
<p>I authorize this clinic/organization/person to:</p> <p><input type="checkbox"/> Send <input type="checkbox"/> Receive <input type="checkbox"/> Exchange</p>	<p>CLINIC/ORGANIZATION/PERSON: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email Address: _____</p> <p><input type="checkbox"/> I am requesting these records for myself as the client</p>												
<p>INFORMATION TO BE RELEASED via:</p> <p><input type="checkbox"/> Fax <input type="checkbox"/> Mail (Certified w/ fee) <input type="checkbox"/> Email (Encrypted) <input type="checkbox"/> Verbal</p>	<table border="0"> <tr> <td><input type="checkbox"/> Discharge Summary/Note</td> <td><input type="checkbox"/> Psychological Test Results</td> </tr> <tr> <td><input type="checkbox"/> Behavioral Programs</td> <td><input type="checkbox"/> Service Plans</td> </tr> <tr> <td><input type="checkbox"/> Academic Testing Reports</td> <td><input type="checkbox"/> Vocational Testing Reports</td> </tr> <tr> <td><input type="checkbox"/> Probation Records</td> <td><input type="checkbox"/> Psychological Reports</td> </tr> <tr> <td><input type="checkbox"/> School Grades/Behavior Records/IEP</td> <td><input type="checkbox"/> Psychotherapy Notes</td> </tr> <tr> <td><input type="checkbox"/> Chemical Dependency Treatment</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Discharge Summary/Note	<input type="checkbox"/> Psychological Test Results	<input type="checkbox"/> Behavioral Programs	<input type="checkbox"/> Service Plans	<input type="checkbox"/> Academic Testing Reports	<input type="checkbox"/> Vocational Testing Reports	<input type="checkbox"/> Probation Records	<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> School Grades/Behavior Records/IEP	<input type="checkbox"/> Psychotherapy Notes	<input type="checkbox"/> Chemical Dependency Treatment	<input type="checkbox"/> Other: _____
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<p>PURPOSE FOR RELEASE OF INFORMATION:</p>	<p><input type="checkbox"/> Planning Treatment or Program <input type="checkbox"/> Legal <input type="checkbox"/> Continuing Care <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Other: _____</p>												
	<p>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 redisclosure of your information by the person or organization who receives your records under this authorization. By signing this authorization, you release River Valley from any and all liability resulting from redisclosure by the recipient. Your signature indicates you have read and understand this form and authorize release of your information as described above.</p>												

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____