MANES FOR CHANGE LLC
1884 MAHOGANY STREET
MORA, MN 55051
320-364-3256

AUTHORIZATION TO RELEASE AND DISCLOSE CLIENT INFORMATION

Client's Name: _____ DOB: _____
Client's Address: _____

I authorize Manes for Change LLC, 1884 Mahogany Street, Mora Minnesota 55051 To:
☐Send ☐Receive ☐ Send and Receive

The following information:

☐All Health Information	☐Diagnostic Assessment	☐Chemical Health Assessment
☐Discharge Summary	☐Treatment Progress	☐Treatment Plan
☐Progress Notes	☐ Recommendations	☐Collateral Information
☐Billing/Payment Information		☐Other: _____

With the following person or business:
Name/Business: _____ Address: _____
Phone Number: _____ Fax Number: _____

For services provided during these dates: _____

The above information will be shared for the following purposes (check all that apply):

☐Assessment/Treatment Planning	☐Case Review
☐Continuing Appropriate Treatment or Program	☐Updating Files
☐Determining Eligibility for Benefits or Program	☐Collaboration of Care
☐Sharing/Discussing Progress Notes	☐Discharge Planning
☐Acknowledgement of Client's Services	☐Insurance/Billing
☐Other: _____	

I am authorizing the information to be shared in the following ways:
☐Verbally ☐ Mailed ☐Written ☐Verbally, Mailed, and Written

The authorization is valid for one year from the date of signature unless alternative expiration is written here:_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1 Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Client: ☐Self ☐Parent ☐Legal Guardian