Release of Information Consent Form –Franchise Locations

Patient/Parent/Guardian/Family Member Requesters ONLY

Important Information Regarding Your Request

1. **Processing of Your Request**
   Since your previous clinic has closed, your request will be processed by the **Ellie Mental Health Minnesota Corporate Medical Records/Health Information Department**.
2. **Limited Access to Records**
   Please note that we only have "read-only" access to your records. This means we are **unable to make any edits, corrections, and/or addendums** to the information we provide.
3. **Accompanying Legal Documents**
   If your request requires or includes any **legal, custodial, guardianship, and/or court documents**, please be sure to attach them or send them to the contact information listed below.
   - We can not guarantee we have access to this information from your previous clinic.
4. **Filling Out the Release of Information Form**
   This release of information form should be completed by the **patient** (if they are over 18) or their **legal parent/guardian**

Contact Information - For any additional documents or questions regarding medical records request for closed franchise locations, please use the contact information below:

Ellie Mental Health Corporate Office Minnesota
1345 Mendota Heights Road, Suite 800
Mendota Heights, MN 55120
Attn: Release of Information
Fax: 651-925-0610
Email: records@elliementalhealth.com
Please do not reach out via phone regarding medical records request for closed franchise locations.

Please ensure that all required forms and documents are completed to avoid any delays in processing your request.

Release of Information Consent Form –Franchise Locations

Patient/Parent/Guardian/Family Member Request

Patient Information

Patient Full Name: **Patient Date of Birth:**
Address: **City/State/Zip:**
Phone Number: **Patient Email:**

Closed Ellie Mental Health Franchise Location

*****To locate your clinic and access your records, all information below is REQUIRED. Incomplete forms will not be processed*****

Address:
City/State/Zip:

I authorize Ellie Mental Health Minnesota, 1370 Mendota Heights Road, Mendota Heights MN 55120, to access & release my protected health information from the above listed closed Ellie Mental Health Franchise location to the person/individual listed below:

Patient/Parent/Guardian/Family Member:

Name:
Address:
City/State/Zip:
Phone Number:
Secure Recipient Email:
*****Please list the email address for the person who needs to receive the requested records, if applicable*****

INFORMATION TO BE RELEASED

Only release specified records below:

- ☐ *Most Recent Psychological Evaluation*
- ☐ *Most Recent Diagnostic Assessment*
- ☐ *Most Recent Treatment Plan*
- ☐ *Most Recent Health Information (Diagnostic Assessment, Treatment Plan, 3 most recent progress notes)*
- ☐ *All health information (including all information listed above but excludes information from a chemical dependency program & psychotherapy notes)*
- ☐ *Discharge Summary*
- ☐ *Progress Notes*
- ☐ *Testing Information*

OR

- Specific dates/years of treatment listed below (This will authorize all medical records to be released that were created within the timeframe listed below. Any records created outside of the timeframe you state below WILL NOT be released)
  - ____

PURPOSE FOR DISCLOSURE:

☐ Coordination of Care
☐ Legal/Court Order
☐ Personal Request
☐ Other: ____

METHOD OF RELEASE:

☐ Mail
☐ Secure Email

I UNDERSTAND THAT:

§ My health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Ellie Mental Health's Privacy Notice.
§ I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Ellie Mental Health's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
§ For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party)
(45 CFR & 164.508 (b)(4)(III))
§ Communications resulting from this authorization will reveal that I receive services at Ellie Mental Health.
§ Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol & drug abuse patient records. However, HIPAA requires Ellie Mental Health to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
§ This authorization may be used by Ellie Mental Health owned or managed programs upon transfer of my care to them.

SIGNATURE

Patient's Signature: ____ *Date:* _____________

OR Authorized Representative's Signature: _____________________ *Date:* ____________

Representative's Name (printed): ____

Representative's Relationship to Patient: ____