1345 Mendota Heights Road, Suite 800 Mendota Heights MN 55120
Phone: 651-313-8080 Fax: 651-925-0610

RELEASE OF HEALTH INFORMATION

1. **PATIENT INFORMATION**

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

2. **I authorize Ellie Mental Health to**

☐ Release Information To (send records to another facility/person)
☐ Obtain Infromation From (receive records from another facility)

Organization/Individual Name:
Mailing Address:
City/State/Zip:
Phone (required): Fax (required):

3. **I authorize the following information to be released**

☐ Most Recent Health Information (Diagnostic Assessment, Treatment Plan, Last 3 Progress Notes)
☐ Most Recent Diagnostic Assessment
☐ Most Recent Treatment Plan
☐ Most Recent Progress Notes (last 3)
☐ Discharge Summary
☐ Most Recent Psychological Evaluation and/or Testing Records
☐ Diagnosis
☐ Other_____
☐ All health information (including all information listed above but excludes information from a chemical dependency program & psychotherapy notes)

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)

☐ _____

4. **Purpose of Disclosure**

☐ Coordination of Care
☐ Legal/Court Order
☐ Personal Request
☐ Other_____
☐ Emergency Contact

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5. Method Of Release & Communication

- ☐ Fax (default, if provided above)
- ☐ Mail
- ☐ Secure Email (PDF)_____
- ☐ Other_____

Health information can be written or spoken. By selecting any category in section 3, you allow us to release written information and verbally discuss your health with the person and/or representative in section 2. If you do not permit us to verbally speak with the person in section 2, indicate that here (checkmark or initials)._____

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): _____

**Please note: Pursuant to MN Statute Sec. 144.3431, minors aged 16 and 17 have the authority to independently sign for their own releases of information, thereby eliminating the necessity for additional parental or guardian signatures. **