RELEASE OF PROTECTED HEALTH INFORMATION

1. CLIENT INFORMATION:

First Name: _____ Middle Initial: _____ Last Name:_____ Date of Birth: ___/___/____

Phone Number: _____ Email: _____ Home Address:_____

City: _____State: _____ Zip Code: _____ Person(s) Completing: _____Relationship:_____

2. I REQUEST THAT HEALTH INFORMATION BE: SENT TO _____ RELEASED FROM _____

Individual/Organization:_____Office Location::_____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

I REQUEST THE FOLLOW METHOD BE USED TO DELIVER RECORDS (CHECK ONE):

___FAX(Administrative Fees May Apply) ___US MAIL (Administrative Fees May Apply) ___TRILOGY CLIENT PORTAL (Up to 1 month Access)
____NO PREFERENCE __OTHER: _____(Limitations to Confidentiality With Email)

3. PROVIDER/ORGANIZATION:
Organization: Trilogy Counseling Services PLLC
Primary Address: 501 4th St. Ste. 201 City: Princeton State:MN Zip Code: 55371
Phone: 763-498-1822 Fax: 763-312-2056 Email: info@trilogycounselingmn.com
Individual Provider(s):
Jacqueline Kelly-Faddler, MS, LPCC - Email: jfaddler@trilogycounselingmn.com: _____
Marshall Albright MA -Email: marshall@trilogycounselingmn.com_____
Clinical Trainee/Intern - Email: admin@trilogycounselingmn.com:_____
Other: _____

4. INFORMATION TO BE RELEASED (Checking all options will invalidate release. Please specify which records are to be released.)

MEDICAL NOTES & EVALUATIONS ____ LEGAL DOCUMENTS ____ EDUCATIONAL RECORDS ____ CHEMICAL DEPENDENCY RECORDS____ PSYCHOLOGICAL EVALUATION & NOTES____PSYCHIATRIC RECORDS____ HOSPITAL RECORDS____ VERBAL/WRITTEN COMMUNICATION BETWEEN PARTIES____DIAGNOSTIC ASSESSMENT(S)____ TREATMENT PLAN(S)____MENTAL HEALTH PROGRESS NOTES____INTAKE PAPERWORK & CONSENTS____ASSESSMENTS____COMMUNICATION NOTE(S)____ SUPERVISION/CONSULTATION NOTE(S)____BILLING RECORDS____

OTHER (SPECIFY NEEDS OR REQUEST WILL BE INVALID):_____

SPECIFIC DATE(S) OF TREATMENT: _____

5. REASON(S) FOR RELEASING INFORMATION

CLIENT REQUEST____ REVIEW OF CARE____TREATMENT/CONTINUED CARE____BILLING/PAYMENT____LEGAL____ COLLABORATION/CONSULT____

OTHER(PLEASE SPECIFY): _____

6. INFORMED CONSENT

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. This consent automatically expires after 1 year from the signature date. I have been informed of 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.
THIS CONSENT WILL END 1 YEAR FROM THE DATE THIS FORM IS SIGNED UNLESS AN EARLIER DATE OR EVENT IS INDICATED BELOW.

7. SIGNATURES

SIGNER'S NAME:_____DOCUMENTATION ON FILE SUPPORTING ABILITY TO SIGN ON BEHALF OF CLIENT: **Y/N/NA (circle one)**

I CONSENT TO THE ABOVE INFORMATION BEING SHARED.

CLIENT/LEGAL REPRESENTATIVE SIGNATURE: _____DATE: _____/_____/_____

SPECIFIED RELEASE END DATE: _____/_____/_____

PLEASE NOTE: Please Note: ROI will be invalid if legal guardian/client signature is not reflected on this form, specific documents or information is not requested, form is not completed in its entirety, or specific date range is not provided for document request. Proof of guardianship may be requested at time of request if not already on file. Trilogy Counseling may take up to 30 days to process requests, though will make best attempts to complete requests within a "timely manner". Trilogy Counseling may also request payment for records as allowed by the state of Minnesota.