Guild, 130 South Wabasha Street, Suite100, St. Paul, MN 55107
651-291-0067 (Phone) 651-291-8555(Fax)

Consent to Release Health Information

Name of Individual _____ Date of Birth _____

I give my consent to release my health records for the purpose of coordinating, managing, and improving the care and services provided to me. *This release will permit individuals and agencies you choose to release and exchange information.*

1. Provider that may release and exchange my information *(contact type, name, location, telephone):*

Contact Type: _____

Contact Name: _____

Address: _____

Phone: _____ Fax: _____

2. Information to be released *(check all that apply):* **Important:** *indicate only what you are authorizing to be released.*

- ☐ Specific dates/years of treatment: _____
- ☐ All Health Information
- ☐ Mental Health Evaluation/Treatment
- ☐ Physical Health Evaluation/Treatment
- ☐ Other (e.g. Housing, Financial): _____

The following information requires special consent by law. You must specifically request for the following information to be released. Check a box below **ONLY if you are specifically requesting this type of information be released:*

- ☐ **Chemical dependency program** (information from a provider that assesses and treats alcohol/drug abuse)
- ☐ **Psychotherapy notes** (this consent cannot be combined with any other authorization for the release of health information)

3. Contact information for person completing form *(optional)*:

Guild Program/Team: _____

Name: _____ Email: _____

Phone: _____ Fax Number: _____

4. Reason for Requesting/Releasing Information

- ☐ Coordination of Care
- ☐ Payment/Billing
- ☐ Emergency Only
- ☐ Other: _____

5. This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: *(optional):*

Date: _____ Or Specific Event: _____

6. I Understand That:

- Information I have selected to be released will be done so strictly to accomplish the reason for release and will be limited to the information necessary to accomplish this purpose.
- I may stop this consent in writing at any time.
- If my information has already been released based on my consent, my request to stop will not work for that information.
- I may refuse to release information. The possible results of not giving consent have been explained to me.
- When health information is sent to a third party, the information could be re-disclosed by the party that receives it and it may no longer be protected by federal and state privacy laws.
- I may ask for a copy of the Notice of Privacy Practices if I need more information.

7. Client Signature: _____ **Date:** _____

Or legal representative's signature: _____ **Date:** _____

Representative's relationship to Client (parent, guardian, etc.): _____

This form ensures that private information about individuals served by Guild is handled respectfully and according to the Minnesota Health Records Act and the Health Information Portability and Accountability Act of 1996 (HIPAA). It is also intended to encourage and assist individuals to be aware of and use their rights and responsibilities about private health information.