Centerville Clinic
7039 20th Ave. S., Centerville, MN 55038
Phone: 651-288-0332 Fax: 651-288-0493

CenterLife Counseling

White Bear Lake Clinic
4444 Centerville Rd. Suite 235, White Bear Lake, MN 55127
Phone: 651-289-3111 Fax: 651-289-3113

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
(Primary Care Physician/Psychiatrist)

Patient's Name: ____________________ Address: ____________________

Phone: ____________________ ____________________

DOB: ____________________ ____________________

I request and authorize ____________________ to release and receive my personal healthcare information between:
(Clinician/Therapist)

(Check appropriate CenterLife Office)

☐ Centerville Clinic
7039 20th Ave S, Centerville, MN 55038
Ph: 651-288-0332; Fax: 651-288-0493

OR

☐ White Bear Lake Clinic
4444 Centerville Rd, Ste 235, White Bear Lake, MN 55127
Ph: 651-289-3111; Fax: 651-289-3113

AND

Individual/Clinician/Clinic to Release Info to:
(Name, Clinic, Address, Phone, Fax)

____
____
____
____
____

This request and authorization applies to:

____ Complete Record ____ Discharge Summary ____ Testing ____ History & Physical

____ Other ____________________

Purpose of Disclosure: ____________________

I understand the consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in compliance of this consent. If revocation is not received, authorization will be considered valid for a period of one year from date the ROI was attained.

The facility, its employees, officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized.

I understand that the information released could contain reference to Substance Abuse, Psychological, and/or Psychiatric Impairment.

To the party receiving this information: this information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFS PART 2.

Client Signature: ____________________ Date Signed: ____________

Guardian Signature: ____________________ Date Signed: ____________

Relationship to Client: ____________________

******NOTE TO PHYSICIAN******

Dear: ____________________

Our mutual client/patient has authorized us to be in communication to coordinate their care. Their Diagnostic Assessment was on ____________ and they will follow up with weekly/bi-weekly appointments and/or were referred to ____________________

Dx: ____________________
____

S/S: ____________________
____

Tx Goals: ____________________
____

Risk Factors/Special Concerns: ____________________
____

Clinician Signature: ____________________ Date: ____________

Updated 9/28/15