Diamond Lake Clinic

Diamond Lake Clinic

5939 Portland Ave S, Minneapolis, MN 55417
Office: (612) 869-4444 Fax: (612) 254-8244

Authorization to Release Health Information

_____ / _____ / _____

First Name, Middle Name, Last Name *Date of Birth*

Address *City* *State* *Zip Code*

I allow: Diamond Lake Clinic - 5939 Portland Ave S Minneapolis, MN 55417
Phone: (612) 869-4444 Fax: (612) 254-8244

To give information to and receive information from:

Name (Organization)

Address

Phone Number *Fax Number* *Email*

I give my permission to disclose/receive the following information regarding mental health:

- ☐ Admission/Intake Summary
- ☐ Diagnosis/ Treatment Plan
- ☐ Progress/Clinic Notes
- ☐ Assessments/Evaluations
- ☐ Conversations Regarding Care
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ EKG Reports
- ☐ Urine Drug Screens Results
- ☐ Emergency Room Report
- ☐ Medications
- ☐ Other (Must Specify): _____

Purpose of Release:

- ☐ Personal
- ☐ Attorney/Litigation
- ☐ Insurance Attorney/ Litigation
- ☐ Continued Care
- ☐ Disability/Social Security
- ☐ Other (Must Specify): _____

By signing below, 1 give my permission for agents of Diamond Lake Clinic to verbally communicate about me in order to arrange for the coordination of care, payment, or services. I understand that may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revoc ation. I also understand that this authorization automatically expires in one year from the date ofmy signature unless I revoke it earlier. Diamond Lake Clinic will not refuse or restrict treatment if I choose not to sign this authorization or if I choose not to sign this authorization or if I revoke it. A photocopy /fax of this authorization will be treated as if it were an original.

Diamond Lake Clinic cannot prevent the re-disclosure of records released as a result of the request and the records may not be subject to privacy rule protections; therefore, Diamond Lake Clinic is released from any and all liability resulting from re-dis closure.

Signature (If signing for a minor patient, I hereby state I have legal authority to sign for the minor.) **Date**

Relationship to patient (If not patient signing)