



**Brighter Possibilities
Child and Family Counseling**
Authorization to Release Protected Health Information

CLIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____ CTSS RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorized Brighter Possibilities Child and Family Counseling (*Print Name of Provider*) to release information from my record as indicated below to:

NAME: Brighter Possibilities Child And Family Counseling Agency (Staff Name)

ADDRESS: 5701 Kentucky Ave N, suite 201 Minneapolis, MN 55428

INFORMATION TO BE RELEASED:

- History and physical exam
- Intake & Assessment (*incl. psych/med. History*)
- Presence in Treatment (*admission/discharge dates*)
- Diagnosis
- Progress notes
- Education/School Records
- Discharge Summary
- Coordination of Care Health Form
- Education/School Records
- Treatment/Service Plan
- Other: (specify) _____

COMMENTS:

PURPOSE OF DISCLOSURE: Treatment/Service Planning Consultation/second opinion Continuation of care
 Legal School Insurance Ongoing Treatment
 Other (please specify): _____

I understand the following:

- ✓ I understand that I may cancel this authorization at any time. To cancel this authorization, I must notify Brighter Possibilities in writing. This authorization will be cancelled once Brighter Possibilities has received my written notice. The exception to this would be if my information has already been released prior to my signing this authorization. In that case, this information would not have been protected by Federal privacy regulations.
- ✓ The information released in response to this authorization may be re-disclosed to other parties.
- ✓ My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be enforced and effect until one year from date of execution at which time this authorization expires

SIGNATURE OF CLIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

WITNESS BY (Brighter Possibilities) STAFF) DATE RELATIONSHIP TO CLIENT