Authorization and Consent
To Release Clinical Information

I authorize ____ to release to or exchange
(Provider Name)

the following types of information with ____
(Specific health care organization or professional's name)

in regard to ____ ______________________
(Client's Name) (Client's Date of Birth)

____
(Client's Home Address)

____
(Client's Phone Number)

for the purpose of ____ .

(Important: indicate only the information that you are authorizing to be released):

____ Presenting problems
____ Diagnosis
____ Professional impressions
____ Psychological or intellectual assessment
____ Termination/Discharge Report
____ Summary of treatment
____ Medical reports
____ Summary of medications
____ Complete case record
____ Other (specify)
____
____
____

I understand that the information released by this authorization will be protected as private data according to the provisions of the Minnesota Health Records Act and, to the extent permitted by law, will not be released to others without my authorization.

I recognize that Mark Halley, Psy.D., L.P. cannot guarantee the privacy of information released by him under this authorization, but it is my intent that the party I designate to receive it will consider it private according to the provision of the Minnesota Health Records Act.

Further, I understand that I may rescind this authorization at any time by giving written notification to the above named parties, and that otherwise, it will expire one year from the date of my signature. A copy of this consent is a valid document.

I fully understand all the above and my consent on this form is freely given.

____________________________________ ________________________________
Client Signature Date

____________________________________ ________________________________
Legally Authorized Representative's Signature (If applicable) Representative's Relationship to Client