



### AUTHORIZATION TO RELEASE INFORMATION

<p>CLIENT INFORMATION</p>	<p>Name: _____ Date of Birth: _____</p> <p>Address: _____ Phone: _____</p> <p>City: _____ State: _____ Zip Code: _____</p>
<p>I authorize this clinic to:</p> <p><input type="checkbox"/> Send <input type="checkbox"/> Receive <input type="checkbox"/> Exchange</p>	<p>Serenity Behavioral Health &amp; Wellness LLC 6375 143rd Street West Savage, MN 55378-2099 Phone: 952-592-2200 Fax: 952-592-2201</p> <p>Provider(s): _____</p>
<p>I authorize this clinic/ organization/person to:</p> <p><input type="checkbox"/> Send <input type="checkbox"/> Receive <input type="checkbox"/> Exchange</p>	<p>Clinic/Organization/Person: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p> <p><input type="checkbox"/> I am requesting these records for myself as the client</p>
<p>INFORMATION TO BE RELEASED via:</p> <p><input type="checkbox"/> Fax <input type="checkbox"/> Mailed (Certified w/fee) <input type="checkbox"/> Emailed (Encrypted) <input type="checkbox"/> Verbal</p>	<p><input type="checkbox"/> Discharge Summary/Notes <input type="checkbox"/> Behavioral Programs <input type="checkbox"/> Academic Testing Reports <input type="checkbox"/> Probation Records <input type="checkbox"/> School Grades/ Behavior <input type="checkbox"/> Records/IEP Chemical <input type="checkbox"/> Dependency Treatment</p> <p><input type="checkbox"/> Psychological Test Results <input type="checkbox"/> Service Plans <input type="checkbox"/> Vocational Testing Reports <input type="checkbox"/> Psychotherapy Notes <input type="checkbox"/> Other: _____</p>
<p>PURPOSE FOR RELEASE OF INFORMATION:</p>	<p><input type="checkbox"/> Planning Treatment or Program <input type="checkbox"/> Continuing Care Other: _____</p> <p><input type="checkbox"/> Legal <input type="checkbox"/> Social Security Disability</p>
	<p>I understand this authorization is voluntary and lasts for one year after the date I sign it unless I enter a different date here: _____. This authorization can be cancelled in writing at any time. A cancellation will not change releases that occur before the cancellation date. A photocopy/fax of this authorization will be treated the same as an original. Serenity Behavioral Health &amp; Wellness LLC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization. By signing this authorization, you release Serenity from any and all liability resulting from redisclosure by the recipient. Your signature indicates you have read and understand this form and authorize release of your information as described above.</p>
	<p>Client Signature: _____ Date: _____</p> <p>Parent/Legal Guardian Signature: _____ Date: _____</p>