SONDER
Behavioral Health & Wellness

Authorization To Release/Exchange Information

Patient Name _____ **Date of Birth** _____

I Authorize:

Hospital/Clinic/School/Person: _____

Address/City/State/Zip: _____

Phone: _____ **Fax**: _____

To Release/Exchange clinical information/documentation with:

Hospital/Clinic/School/Person: _____

Address/City/State/Zip: _____

Phone: _____ **Fax**: _____

PURPOSE FOR RELEASE OF INFORMATION:

Check ALL appropriate box(es)

- ☐ Care Coordination
- ☐ Social Security/Disability
- ☐ Insurance Claims/Payments
- ☐ Personal Record Keeping
- ☐ Planning Treatment or Program
- ☐ Legal
- ☐ School
- ☐ Other: _____

***Fees may be charged in accordance with MN Statute 144.292 an Federal Rule 45 CFR § 164.524*

REQUESTED INFORMATION:

Fax, Verbal and/or Mail

Check ALL appropriate box(es)

- ☐ Psych Intake / Diagnostic Assessment
- ☐ Psych Evaluation / Testing Results
- ☐ Progress Notes / Treatment Plan
- ☐ Emergency Department Records
- ☐ Admission and / or Discharge Records
- ☐ **For dates of service**: _____
- ☐ Other:_____
- ☐ Treatment Program Records
- ☐ Medication History
- ☐ Lab Results
- ☐ Cardiac / EKG Testing Results
- ☐ School Records / Testing / IEP / 504
- ☐ **All Health Information**

TERMS AND CONDITIONS OF THIS RELEASE:

- I understand that my health record may include information related to mental or behavioral health including chemical dependency.
- I understand that I have the right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here**:

_____ _____

Signature of Patient / Parent / Guardian **Date Signed**

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

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