AUTHORIZATION TO RELEASE HEALTH INFORMATION

This entire authorization must be filled out to the best of your ability. Please print or type. Read each section and enter all of the needed information. If all areas are not filled out completely and accurately, this authorization will be returned to you requesting the additional needed information. If you have questions on how to fill out this form please call *Clear Horizons, LLC* at 612-913-8411.

Client Name_____ADDRESS_____

PHONE_____ Last four of SSN_____DATE OF BIRTH____/ _____/ _____ CHART NUMBER_____

I authorize the use or disclosure of the above named individual's health information as described below.

The type and amount of information to be used or disclosed is as follows (check those that apply and include dates where appropriate):

- o Diagnostic Assessment
- o Progress Notes
- o Most recent discharge summary
- o Psychological Examinations
- o Other (specify) _____
- o Functional Assessments
- o LOCUS (if available)
- o Entire Record

For the following date(s) of treatment or condition: _____
This information is needed for the purpose of: _____

Information to be released From and/or To:	Information to be released To and/or From:
Name: _____	Name: Clear Horizons, LLC--Aki Hughes-Polk & Staff
Address: _____	Address: P.O. Box 490272
_____	Blaine MN 55449
Phone: _____	Phone: 612-913-8411 Fax: 866-896-8275

1. I understand that the information in my health record may include information relating to behavioral or mental services and treatment for alcohol and drug abuse. If contained in the health record this information may be disclosed unless indicated here by initialing on this line _____ and checking the information not to be disclosed. Do not release the following information (check all that apply):

☐ Behavioral or Mental Services ☐ Drug / Alcohol Abuse

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition - _____ (not to exceed one year from date). If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date signed. After one year another form must be completed to continue the service of authorization that you request.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure of the information and may not me protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact *Clear Horizons, LLC* release of information provider at 612-913-8411.

By signing I acknowledge that I have read, understand and agree with the above. By signing I further understand that I may be charged in accordance with state and federal statutes for the processing of the requested records.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness