CEDAR BRANCH COUNSELING GROUP

2232 2nd Ave. E, Suite 5
INTERNATIONAL FALLS, MN 56649
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CONSENT TO RELEASE MEDICAL AND/OR BEHAVIORAL HEALTH PATIENT RECORDS AND INFORMATION

CLIENT NAME_____DOB_____

I authorize disclosure and release of records/information about me between:

Cedar Branch Counseling Group, PLLC
2232 2nd Ave. E., Suite 5
International Falls, MN 56649
Info@cedarbranchcounseling.com

and

Name _____

Address_____

_____

Phone_____

I authorize Cedar Branch Counseling Group to:

_____ **Give Information to the above Person(s)/Agency as follows:**
_____ **Receive Information from the Person(s)/Agency as follows:**

_____ Diagnostic Assessment
_____ Chemical History/Assessment
_____ Presence in Treatment
_____ Progress Records/Reports
_____ Coordination of Care
_____ Other: _____

_____ Medications/ Medication Management
_____ Primary Discharge Summary
_____ Aftercare Planning/Discharge Summary
_____ Change in Condition or Status
_____ Case management coordination
_____ Records for Dates
____/____/____through ____/_____/_____

The information is for the specific purpose of best practices of coordination of care. I understand releasing information can consist of Telephone, Written, Questionnaire, Email, Conference, Facsimile or In Person. **I understand that my consent terminates one year from today's date.**
(Maximum of one year unless I choose to revoke it earlier)

I understand that my records are protected under the federal HIPPA regulations governing confidentiality of Patient Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires within one year of signature. I understand this communication will reveal my presence as a patient in Mental Health Therapy.

CLIENT SIGNATURE_•_____DATE_____

STAFF SIGNATURE_____DATE_____