HORIZON PSYCHIATRY
21370 John Milless Dr. Suite 210 Rogers, MN 55374 P: (763)428-2288 F: (763)428-2132

Authorization to Release and Disclose Patient Information

(1) Patient Information

Name: _____ DOB: ____/____/_____
Street Address: _____ Phone: ( )_____- _____
City: _____ State: _____ Zip Code: _____

(2) Authorization

I give permission for Horizon Psychiatry, LLC to:

- ☐ Release to
- ☐ Receive from
- ☐ Both Release & Receive from

Organization(s)/Name: _____ Phone: ( )_____- _____
Street Address: _____ Fax: ( )_____ - _____
City: _____ State: _____ Zip Code: _____

(3) Information to Be Released

- ☐ Specific dates/years of treatment: _____
- ☐ All health information
- ☐ Verbal only – do not release any health records

OR only release specific portions of your health record as checked below:

- ☐ Lab reports
- ☐ Medications
- ☐ Psychological/Neuro-psych testing
- ☐ Assessment diagnostic form, 3 most recent progress notes & treatment plan
- ☐ Other information or instructions: _____

All health records pertaining to alcohol, drug abuse and AIDS related illness will be released unless indicated in writing here: _____

(4) Reason(s) For Releasing Information

- ☐ Treatment/continuity of care
- ☐ Payment
- ☐ Legal
- ☐ Social Security Disability
- ☐ Other reason(s): _____
- ☐ Personal use
- ☐ Insurance application
- ☐ Social Security Appeal

Disclaimer: I understand by signing this form, I am requesting health information specified in Section 3 be sent to the third party named in Section 2. I understand if the organization named in Section 2 is a health care provider they will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form. I understand it is my right to revoke this authorization "in writing" at any time; otherwise this agreement will be valid one year from signature date.
Redisclosure: Information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Signature of patient: _____ Date: ____/____/____
OR legally authorized representative's signature: _____ Date: ____/____/_____
Representative's relationship to patient (parent, guardian, etc.): _____