PrairieCare medical group	Patient Identification	RM.204.F01
Authorization for Release of Information		

Patient Name: _____ **Date of Birth:** _____

1.	**Pediatric Integrative Medicine Clinic - Chaska (111 Hundertmark Road, Chaska, MN 55318)**	**Ph: 952-903-1350 Fax: 952-426-3856**
2.	**PrairieCare Medical Group Clinic/Adult IOP - Chaska (111 Hundertmark Road, Chaska, MN 55318)**	**Ph: 952-903-1350 Fax: 952-426-3856**
3.	**PrairieCare Adult IOP - Edina (6363 France Avenue South, Edina, MN 55435)**	**Ph: 952-230-9100 Fax: 952-922-2049**
4.	**PrairieCare Medical Group Clinic - Edina (6363 France Avenue, Edina, MN 55435)**	**Ph: 952-230-9100 Fax: 952-922-2525**
5.	**PrairieCare Medical Group Clinic – Mankato (201 North Broad Street, Mankato, MN 56001**	**Ph: 507-322-5464 Fax: 507-387-4785**
6.	**PrairieCare Medical Group Clinic - Maplewood (2001 Bean Avenue, Maplewood, MN 55109)**	**Ph: 952-737-4500 Fax: 651-209-0514**
7.	**PrairieCare Medical Group Clinic/IOP – MOB (5500 94th Avenue North, Brooklyn Park, MN 55443)**	**Ph: 763-762-6800 Fax: 763-315-6673**
8.	**PrairieCare Medical Group Clinic/IOP - Rochester (1620 Greenview Drive, Rochester, MN 55901)**	**Ph: 507-218-3700 Fax: 507-258-5503**
9.	**PrairieCare Adult IOP - Woodbury (659 Bielenberg Drive Suite 200, Woodbury, MN 55125)**	**Ph: 651-259-9760 Fax: 651-259-9770**
10.	**PrairieCare Medical Group Clinic - Woodbury (659 Bielenberg Drive Suite 200, Woodbury, MN 55125)**	**Ph: 651-259-9710 Fax: 651-259-9780**

☐ **I authorize** PrairieCare Medical Group Program #_____ (*select number from list above*) to **REQUEST** information **FROM:**

☐ **I authorize** PrairieCare Medical Group Program #_____ (*select number from list above*) to **RELEASE** information **TO:**

Provider / Organization: _____

Address: _____

Fax #: _____ Telephone: _____

Provide information via: ☐Written ☐Fax ☐Telephone ☐Secure Email ☐Unsecured Email **(for communication directly with patients only)**

INFORMATION TO BE RELEASED (NOTE: INDIVIDUALLY CHECK ALL THAT APPLY)

	Psychiatric Assessment		Treatment Plans
	Discharge Summary		Progress in Treatment
	Discharge Plans PHP, IOP, Outpatient Discharge Date _____		Medical Consults
	Psychological Consult/Testing		Acknowledgement of Patient's Access of Service
	Alcohol/Drug Abuse Evaluation/Treatment **(Requires patient to consent)**		History & Physical
	Lab Results **(CD / Pregnancy lab results require patient to consent)**		Information re: HIV/AIDS status
	Reproductive Health Information **(Requires patient to consent)**		Other:

This information will be used for: (check all that apply)

☐Assessment, Treatment ☐Coordination and Follow up ☐Education ☐Insurance Purposes
☐Psychological Evaluation/testing ☐Discharge Planning ☐Legal ☐Acknowledge Patient's Access of Service/Referral
☐Other (must specify) _____

This Authorization remains in effect for one year from date signed, or: _____
(Specify date, event, or conditions that cause authorization to expire)

I understand that I may revoke this authorization at anytime except to the extent that action has been taken in reliance on it. Refer to PrairieCare's Notice of Privacy Practices for instructions regarding how to revoke authorizations or to inspect or receive copies of this information. A photocopy/fax of this authorization will be treated in the same way as the original. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits or payment status. Once information is released, as authorized by this form, PrairieCare, its employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

NOTE: PATIENTS MUST PERSONALLY CONSENT FOR ALCOHOL/DRUG ABUSE AND REPRODUCTIVE HEALTH INFORMATION. PARENTAL CONSENT IS NOT VALID.
NOTE: PATIENTS 16 AND OLDER MUST PERSONALLY CONSENT FOR ALL MENTAL HEALTH RECORDS. PARENTAL CONSENT IS NOT VALID.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent / Guardian Date Name of Staff that obtained and reviewed

Office use only: Records released by: _____ Date: _____ MR# _____