TOUCHSTONE
mental health

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Touchstone Mental Health
2312 Snelling Avenue Minneapolis, MN 55404
Phone: (612) 874-6409 Fax: (612) 874-0157

Client Information			
Client name		Date of Birth	
Previous name(s):		Address	
Phone		E-Mail	

Consent to Request and/or Release

I authorize Touchstone Mental Health to (check all that apply):

☐	Request and Use the following Protected Health Information from the provider(s) below	☐	Release the following information to the provider(s) below

My consent above allows Touchstone to Use and/or Request the following types of information:

☐	Economic benefits & financial information	☐	Court and correctional records
☐	Treatment plan or ISP	☐	Vocational; job status, vocational plan, reports
☐	Chemical health history, assessment & treatment	☐	Housing status & information
☐	Academic status & transcripts	☐	Progress reports
☐	Medical history, assessment & treatment	☐	Medication records
☐	Lab reports	☐	Mental Health history, assessment & treatment

Specific dates/years of treatment (optional)	
Other Special Instructions/Limitations	

Special Consent

The following information requires special consent by law. Even if you indicate all health information above, you must specifically authorize the following information in order for it to be requested or released:

☐	**Chemical dependency program (see definition in instructions)**	☐	**Psychotherapy notes (this consent cannot be combined with any other; see instructions)**

My consent above applies to the following individuals/provider(s):

Individual/Provider Name	
Primary Contact	
Address	
Phone Number	
Fax Number	

Contact Information for person completing form

Name	
Daytime Phone	
Touchstone Program	
E-Mail Address	

Reason(s) for Request or Release

By authorizing the release or request of records, you are giving permission for written information to be released and used by Touchstone Mental Health and its staff to talk to a person or provider specified above about your health information.

Reason(s) for releasing/requesting information

	Coordination of Care	
	Payment	
	Emergency Only	
	Other (please explain)	

I understand that by signing this form, I am requesting that the health information specified above will be either sent or received.

I may stop this consent at any time by writing to the organization(s), facility and/or professional(s) named above.

Any request to revoke release is applicable from that date forward.

I understand that when the health information specified above is sent to the third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named above is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Release Expiration Date	
Specific Event	

_____ _____

Signature of client or personal representative Date

_____ _____

Signature of person obtaining authorization Date

_____ _____

Print name of client or personal representative Description of personal representative's authority