AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to exchange/gather protected health information for your clinical record with/and/or by the person(s) you designate.

I _____ authorize:

DOB _____

Parkdale Therapy Group, LLC
1000 Shelard Parkway, Suite 520
St. Louis Park, MN 55426-1053
952-224-0399, Fax 952-224-0396

and/or his or her administrative and clinical staff (cross out if not applicable), to request/release/exchange this information:

____Initial Assessment/History
____Past and Ongoing Case notes
____Summary of Treatment
____Medical/Lab Results
____Consultation Reports
___All of the above
___Other (specify) _____

____Psychological Testing, Evaluation & Treatment Plan
____Chemical Dependency Evaluation & Treatment Plan
____Neurological Testing, Evaluation & Treatment Plan
____Educational Assessments, Evaluation & Treatment Plan
____ Legal/Police/Criminal Records

(Description of the information you want disclosed should be as specific and detailed as possible.)

This information should only be requested/released/exchanged to or with:

_____ (Individual(s)/Clinic)

_____(Address)

_____ (Phone/Fax)

I am requesting my counselor to release/exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

At the request of the individuals

This authorization **will automatically expire one year after the signing of this form**, unless indicated otherwise below:

___ 30 days after last date of service
___ Upon my written request
___ Immediately after requested information is received
___ Other (Specify)_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have acted in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date