EMPOWER

Therapeutic Support Services LLC

227 Colfax Ave N Ste 15
Minneapolis, MN 55405

AUTHORIZATION FOR THE RELEASE / EXCHANGE OF INFORMATION

Client	Date of Birth	County	
Street Address	City	____________ State	_____________ Zip Code

Legal Parent or Guardian (Print Name):____

Address ____City/State/Zip __________________________________

Phone Number ___________________________________ Relationship ______________________________

I authorize **EMPOWER Therapeutic Support Services LLC** to release/exchange information to/with the following:

I am agreeing to release/exchange information to:	**Primary Insurance**	**Primary Care Physician**	**Social Services**			
Check all that apply:						
All materials in records						
Medical History and Treatment						
Psychosocial History						
Assessment and Diagnosis						
Progress Notes and Treatment Plans						
Juvenile Court Records						
Medication and Treatment Records						
Summary of Psychological Testing						
Discharge Summary						
Financial and Health Insurance Data						
Only in an emergency						
Educational/School Records						
Other:____________						

I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.

I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that the information or records listed above will not be used for any purpose other than the intended use. The re~release of this information to parties other than those named above is prohibited.

I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below.

This authorization automatically expires, unless otherwise provided by state law, on (specific date):____________

______________________________ ______________________________ __________________

Signature of Patient/Legal Guardian Relationship to Patient (if applicable) Date

_________________________________ _____________

Signature of Witness/ Requestor of Information Date