Authorization to Release Protected Health Information

Full Name *(print)* _____ **Birth Date** *(mm/dd/yyyy)* _____

Release Information From ***(check one)***	**Release Information To** ***(check one)***
☐ **Leigh Rosenberg, MSW, Tikkun Healing and Wellness**, PO Box 7631, Minneapolis, MN 55407 (ph 612-351-1816)	☐ **Leigh Rosenberg, MSW, Tikkun Healing and Wellness**, PO Box 7631, Minneapolis, MN 55407 (ph 612-351-1816)
☐ **Other** *(Include facility/person, address, and phone/fax)*	☐ **Other** *(Include facility/person, address, and phone/fax)*

Purpose of Release

☐ Treatment/continued care ☐ Personal ☐ Legal Purposes ☐ Insurance application

☐ Disability determination ☐ Payment of insurance claim ☐ Other *(specify):*

Information To Be Released

I request release of the following information. I understand this information will be helpful to one or both parties in providing services to me. *Check all that apply. (Please use separate form for release of psychotherapy notes [personal notes of therapist] outside of documented case notes.)*

(Check all that apply)

☐ No restrictions ☐ Attendance records ☐ Billing information

☐ Intake forms ☐ Payment of insurance claims ☐ Other *(specify):*

☐ Case notes ☐ Psychotherapy notes *(only) Not released unless specified.*

☐ Consult notes

☐ **Verbal info**

☐ **Written/print info**

Service Dates *(optional)* **From:** _____ **To:** _____ **Date needed by** *(optional):* _____

I understand the information to be released may include records related to behavior and/or mental health care, and alcohol and drug abuse treatment. This authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider releasing the information. The provider will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or dislcosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

This authorization will expire: *(check one)* ☐ 30 days after termination of treatment ☐ immediately after requested information is received ☐ upon my written request ☐ other *(specify)*: _____.

ATTENTION: Please read carefully. By signing, you agree that you understand and accept the terms on this legal document.

- **If the patient/client is 18 years of age or older**, the patient/client must sign and date the form.
- **If the patient/client is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.
  - ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

Signature ***(required)*** **Date signed** ***(required)*** _____

Name of person signing and relationship, if not patient/client *(please print)* _____

Mailing address of patient/client *(Street address, City, State, Zip)* _____

Phone _____ **Email** _____

Tikkun Healing and Wellness, LLC, *is owned by* ***Leigh Rosenberg, MSW, LGSW*** *and includes the clinical practice of this provider. This document applies to services rendered through Tikkun Healing and Wellness, LLC.* *(Updated 5/2024).*