valley medical & wellness

• Burnsville • Minneapolis • Woodbury
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RELEASE OF INFORMATION & CONSENT FORM

It is important that health care providers work together. As such, Valley Medical and Wellness would like your permission to communicate and obtain medical records, when necessary, with your medical providers.

This release form is enforceable from _____ (today) until 1 year from today's date.

Patient Name		DOB	
SSN		Phone	
Address		City, State, Zip	

Organization	
Clinic Name	
Address	
Contact Info.	Phone: Fax:

I, _____ (Patient Name), hereby authorize the release and exchange of information specified below between the above listed organization and **Valley Medical and Wellness.**

This release of information shall be limited to the following specific types of information: ____ ALL MEDICAL RECORDS

___Assessment
___Diagnosis
___Treatment Plan or Summary
___Current Treatment Update
___Medication Management Information
___Presence/Participation in Treatment
___Nursing/Medical Information
___Toxicological Reports/Drug Screens
___Educational Information
___Psychiatric/Psychological Evaluations
___Drug Use/Addiction History
___Toxicological Reports/Drug Screens
___Education Information
___Discharge/Transfer Summary
___Continuing Care Plan
___Demographic Information
___Progress in Treatment/Notes
___Lab Results
___Imaging: _____
___Other: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to **Valley Medical and Wellness** in writing. However, the revocation will not apply to records already released. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

Patient Signature: _____ Date: _____